

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

12981

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12978

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Washington</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Mont</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		c. LENGTH OF STAY IN 1b <i>45 minutes</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Darnestown</i> <i>15 X - 2</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Western Md Chronic Hospital</i>				d. STREET ADDRESS <i>Seneca Road</i>			
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>Ely</i> Last <i>Andrews</i>				4. DATE OF DEATH Month <i>Nov</i> Day <i>30</i> Year <i>1958</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec-6-1892</i>	
9. AGE (In years last birthday) <i>65</i> yrs.		IF UNDER 1 YEAR Months <i>6</i> Days <i>5</i>		IF UNDER 24 HRS. Hours <i>6</i> Min. <i>5</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Vice President</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Steamship Lines</i>		11. BIRTHPLACE (State or foreign country) <i>Cokes N. Y.</i>	
13. FATHER'S NAME <i>Clarence Andrews</i>				14. MOTHER'S MAIDEN NAME <i>Martha Oonslow</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>				16. SOCIAL SECURITY NO. <i>WW I</i>		17. INFORMANT <i>Mrs Dorothy Andrews</i> Address <i>Darnestown Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>Coronary Thelusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute Myocardial Infarction</i> DUE TO <i>6 yrs</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>5 min.</i> INTERVAL BETWEEN ONSET AND DEATH <i>6 yrs</i>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <i>o. m.</i> <i>p. m.</i> <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>[Signature]</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>J. E. W. H. T. Jr.</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>12-3-58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Darnestown Church Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Darnestown Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Scott F. Minnich</i>				ADDRESS <i>Box Hagerstown, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 3 '58</i>	
						24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frawls</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12982

## CERTIFICATE OF DEATH

Reg. Dist. No.

12979

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>67 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>		f. STREET ADDRESS <b>339 N. Mulberry St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Luther</b> Middle <b>Harold</b> Last <b>Bair</b>		4. DATE OF DEATH Month <b>November</b> Day <b>8</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 28, 1879</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabinet maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Organ</b>	
11. BIRTHPLACE (State or foreign country) <b>westminister Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Issac Bair</b>		14. MOTHER'S MAIDEN NAME <b>Catherine V. Barnes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-09-3316</b>	
17. INFORMANT <b>Mrs. Elizabeth M. Bair</b>		Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atheromatous Occlusion Coronary Artery</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bleeding Sigmoid Diverticuli</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week.</b> <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 5, 1958</b> to <b>Nov. 8, 1958</b> , that I last saw the deceased alive on <b>Nov. 7, 1958</b> , and that death occurred at <b>2:00 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>119 North Potomac Street</b> DATE SIGNED <b>11-9-58</b>			
ACTUAL SIGNATURE <b>R.A. Bell</b>		M.D. <b>119 North Potomac Street</b>	
PHYSICIAN'S NAME (Type) <b>R.A. Bell, M.D.</b>		<b>Hagerstown, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-10-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>NOV 12 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
PLACE OF BIRTH [REDACTED]		DATE OF BIRTH [REDACTED]		TIME OF BIRTH [REDACTED]	
PLACE OF DEATH [REDACTED]		DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		PLACE OF INTERMENT [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF PHYSICIAN [REDACTED]	
SIGNATURE OF CLERK [REDACTED]		SIGNATURE OF REGISTRAR [REDACTED]		SIGNATURE OF JUDGE [REDACTED]	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12983

Item 9 Film 236 12-1-58 et

## CERTIFICATE OF DEATH

12980

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. Co. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>A</b> Last <b>Baker</b>		4. DATE OF DEATH Month <b>11</b> Day <b>21</b> Year <b>19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 21, 1899</b>
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>11</b> Days <b>21</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>newspaper slsm.</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Baker</b>		14. MOTHER'S MAIDEN NAME <b>Anna Stickell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Mildred McQuigg</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lebar Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>490X</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>20 Nov 1958</b> , to <b>21 Nov 1958</b> , that I last saw the deceased alive on <b>21 Nov 1958</b> , and that death occurred at <b>5:58 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>F F Lusby</b>		ADDRESS (Street, city or town, state) <b>230 N Potomac St Hagerstown Md</b>	
PHYSICIAN'S NAME (Type) <b>F F Lusby</b>		DATE SIGNED <b>21 Nov 58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>11-24-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>NOV 25 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12984

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LOUISE MILLER BARNES</b>		4. DATE OF DEATH Month Day Year <b>November 21 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 23, 1912</b>
9. AGE (In years last birthday) <b>46 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Adelaide, Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James F. Miller</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth Livingstone</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>220-18-0895</b>		17. INFORMANT Address <b>Mrs. Doris Aycoth Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic glomerular nephritis</b> 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Regeneration -</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b> <b>Myocardial</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 19/58</b> to <b>Nov 21, 1958</b> , that I last saw the deceased alive on <b>Nov 21, 1958</b> , and that death occurred at <b>9 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>159 W. Washington St., Hagerstown, Maryland</b> DATE SIGNED <b>11/21/58</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
22b. DATE THEREOF <b>11/24/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>		24a. REC'D BY REGISTRAR <b>NOV 24 '58</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Meyer</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hume</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

12985 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

12982

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>		d. STREET ADDRESS <b>1143 E. ANTIETAM ST.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>METTIE</b> Middle <b>GORDELIA</b> Last <b>BENCHOFF</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>4</b> Year <b>19 58</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/9/1876</b>
9. AGE (In years last birthday) <b>82 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HAMILTON L. HARBAUGH</b>		14. MOTHER'S MAIDEN NAME <b>CORNELIA A. PRYOR</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MR. LAURAN H. BENCHOFF</b>		Address <b>SMITHSBURG MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe Arterio Sclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>with myocardial failure</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs +</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 1953</b> , to <b>4 Nov 1958</b> , that I last saw the deceased alive on <b>3 Nov 1958</b> , and that death occurred at <b>2 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>F F Lusby</b>		DATE SIGNED <b>5 Nov 58</b>	
PHYSICIAN'S NAME (Type) <b>F F Lusby</b>		ADDRESS (Street, city or town, state) <b>238 N Potomac Hagerstown Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11/6/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>BURNS HILL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>WAYNESBORO PENNA.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment, Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 7 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>

CERTIFICATE OF DEATH

FILE NO.

DATE OF BIRTH

DEATH

PLACE OF BIRTH

TO

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH



12986

CERTIFICATE OF DEATH

12983

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. STREET ADDRESS <u>Mt. Tammany</u>	
3. NAME OF DECEASED (Type or print) First <u>Gordon</u> Middle <u>Bruce</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23 1958</u>
9. AGE (In years last birthday) yrs. <u>3</u>		IF UNDER 1 YEAR: Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Bruce B. Brown</u>		14. MOTHER'S MAIDEN NAME <u>Martha E. Deeter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mr. Bruce B. Brown</u>		Address <u>Mt. Tammany Williamsport Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mattig's Congenital defect</u> DUE TO <u>Congenital heart disease,</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>abscission of duodenum,</u> DUE TO (c) <u>malrotation of colon</u>		INTERVAL BETWEEN ONSET AND DEATH <u>set up</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Surgical bypass of duodenum via duodenojejunostomy</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <u>19</u> Month <u>Nov.</u> Day <u>28</u> Year <u>1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 23, 1958</u> , to <u>Nov. 28, 1958</u> , that I last saw the deceased alive on <u>Nov. 28, 1958</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. L. Parker</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>11/28/58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 30-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Williamsport Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Loefer</u>		24a. REC'D BY REGISTRAR <u>DEC 1 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>			

2081374XV5



12987

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>6 Hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pangborn Corp.</u>				d. STREET ADDRESS <u>12 Wynnwood Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>JOSEPH REESE BROWN</u>				4. DATE OF DEATH <u>November 14 1958</u> Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15 1892</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assembler</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pangborn Corp</u>		11. BIRTHPLACE (State or foreign country) <u>PA,</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>No Record</u>				14. MOTHER'S MAIDEN NAME <u>No Record</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>175-03-4084</u>		17. INFORMANT <u>Mrs Edna S. Brown</u> Address <u>12 Wynnwood Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Heart disease with</u> <u>420.0</u> DUE TO <u>angina pectoris and terminal Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>June 1952</u> , to <u>14 M</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>20 Oct</u> , 19 <u>58</u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. F. Lusby</u>				ADDRESS (Street, city or town, state) <u>230 N Potomac</u> DATE SIGNED <u>15th 58</u>			
PHYSICIAN'S NAME (Type) <u>F. F. Lusby</u>				<u>Hagerstown Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/17/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 18 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12988

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>4 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Martin Manor Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LENA</b> Middle <b>ELIZABETH</b> Last <b>BURDICK</b>				4. DATE OF DEATH Month <b>November</b> Day <b>21</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 29, 1888</b>	
9. AGE (In years lost birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>? Wernert</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Maj. William A. Burdick Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General arteriosclerosis with cerebral</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>thrombosis -</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Degenerative joint Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 1</b> , 1957, to <b>Nov 21</b> , 1958, that I last saw the deceased alive on <b>Nov 20</b> , 1958, and that death occurred at <b>12:45</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>217 W. Washington St. Hagerstown, Md.</b> DATE SIGNED <b>11-21-58</b>							
ACTUAL SIGNATURE <b>Edward W. Ditto</b> , M.D.							
PHYSICIAN'S NAME (Type) <b>Edward W. Ditto</b>				<b>111 Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/24/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b> <b>3. Franklin Street</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 24 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delayed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEW ZEALAND STATE DEPARTMENT OF HEALTH - WELLINGTON



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 12989  
 CERTIFICATE OF DEATH

12986

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN Ib <u>1 Hr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>		e. STREET ADDRESS <u>1329 Salem Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>OTTO BRADFORD BUSSARD</u>		4. DATE OF DEATH Month Day Year <u>November 20 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jany 31 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone Mason</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elias Bussard</u>		14. MOTHER'S MAIDEN NAME <u>Emma Keller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>313-12-7436</u>	
17. INFORMANT <u>Mrs Minnie D. Bussard</u>		Address <u>1329 Salem Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerosis, Severe, Generalized</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 pm +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 1956</u> , to <u>20 Nov 1958</u> , that I last saw the deceased alive on <u>19 Nov 1958</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F F Lusby</u>		DATE SIGNED <u>20 Nov 58</u>	
PHYSICIAN'S NAME (Type) <u>F F Lusby</u>		ADDRESS (Street, city or town, state) <u>2301 Polomae St Hagerstown</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/22/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ch. of God Cemetary</u>	22d. LOCATION (City, town, or county) (State) <u>Broadfording Wash. Co Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 24 '58</u>	
ADDRESS <u>Hagerstown Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12987

12990

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <span style="float: right;">MARYLAND</span>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Washington</b></span>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>20 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. STREET ADDRESS <b>5 Moller Ave.</b>	
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-between;"><span>First <b>JOHN</b></span><span>Middle <b>DAVID</b></span><span>Last <b>BUTERBAUGH</b></span></div>		4. DATE OF DEATH <div style="display: flex; justify-content: space-between;"><span>Month <b>Nov.</b></span><span>Day <b>1</b></span><span>Year <b>1958</b></span></div>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 18, 1881</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Fulton County, Penna.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>George Buterbaugh</b>		14. MOTHER'S MAIDEN NAME <b>Henryette Kizer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-16-0934</b>	
17. INFORMANT Address <b>Mrs. J.E. Sarco 5 Moller Ave. Hagerstown, Md.</b>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} <div style="border: 1px solid black; padding: 5px;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Closed fracture lt..tibia &amp; filula &amp; Lt femur</b> <b>812X</b> DUE TO <b>Severe concussion and shock</b></p> <p>Conditions, if any, which gave rise to immediate cause (b) DUE TO <b>-----</b></p> <p>(a), stating the underlying cause last. (c) DUE TO <b>-----</b></p> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-----</b></p>			INTERVAL BETWEEN ONSET AND DEATH <b>-----</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Stepped off curb into path of oncoming automobile</b>	
20c. TIME OF INJURY Month, Day, Year <b>10:34 PM 11-1-58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Hagerstown Wash Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		DATE SIGNED <b>11-3-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/4/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 5 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Howard</b>		24c. REGISTRAR'S SIGNATURE <b>Arthur L. Howard</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12-30

6066-111A-111B

Death occurred at home of decedent

Decedent was found dead at home of decedent

12-30-1911

1. Cause of death: ☐ Heart ☐ Lungs ☐ Kidneys ☐ Liver ☐ Stomach ☐ Intestines ☐ Pancreas ☐ Spleen ☐ Bladder ☐ Uterus ☐ Vagina ☐ Prostate ☐ Testes ☐ Ovaries ☐ Pituitary ☐ Thyroid ☐ Adrenals ☐ Pineal ☐ Hypothalamus ☐ Hypophysis ☐ Pituitary ☐ Thyroid ☐ Adrenals ☐ Pineal ☐ Hypothalamus ☐ Hypophysis

2. Manner of death: ☐ Natural ☐ Accidental ☐ Suicide ☐ Homicide ☐ Undetermined

3. Name of physician: ☐ J. H. Smith ☐ J. H. Jones ☐ J. H. Brown ☐ J. H. White ☐ J. H. Black ☐ J. H. Green ☐ J. H. Gray ☐ J. H. Blue ☐ J. H. Red ☐ J. H. Yellow ☐ J. H. Purple ☐ J. H. Pink ☐ J. H. Brown

13038

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>				e. STREET ADDRESS <b>105 Washington St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Meda</b> Middle <b>Estella</b> Last <b>Carr</b>				4. DATE OF DEATH Month <b>11</b> Day <b>22</b> Year <b>19 58</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 19. 1885</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>3</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Household</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hancock Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>George McLaughlin</b>				14. MOTHER'S MAIDEN NAME <b>Mary Myers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
17. INFORMANT <b>Mrs Arthur White</b>				Address <b>W. Main St. Hancock Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) DUE TO <b>Myocardial Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Coronary disease</b> (c) INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Nov 3</b> , 19 <b>58</b> to <b>Nov 22</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Nov 22</b> , 19 <b>58</b> , and that death occurred at <b>9:25</b> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. M. SHAFER</b> M.D.				ADDRESS (Street, city or town, state) <b>Hancock Md.</b>			
DATE SIGNED <b>11/22/58</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11.26.58</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>St Thomas</b>				22d. LOCATION (City, town, or county) (State) <b>Hancock Washington Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward L. Groves</b>				ADDRESS <b>Hancock Md.</b>			
24a. REC'D BY REGISTRAR <b>NOV 28 '58</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ARMY AND STATE DEPARTMENT OF HEALTH—BUTLER 13

2502

✱      ✱



1  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12991**  
**CERTIFICATE OF DEATH**

12989

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>		c. LENGTH OF STAY IN TB <u>36 yrs.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2022 Virginia Ave.</u>		d. STREET ADDRESS <u>1 2022 Virginia Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>Earl</u> Last <u>Chilcote</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>3</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 18 1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>17</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret'd Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Buildings</u>	
11. BIRTHPLACE (State or foreign country) <u>Huntington Co.; Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Henry Chilcote</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Bowman</u>	
15. WAS DECEASED SERVING IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215 20 8235A</u>	
17. INFORMANT Address <u>2022 Virginia Ave Hagerstown Md</u> <u>Mrs. Margaret Chilcote</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>1950</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 1, 1958</u> to <u>Nov 3, 1958</u> that I last saw the deceased alive on <u>Nov 3, 1958</u> and that death occurred at <u>3:40</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. W. Beechey</u> M.D.		ADDRESS (Street, city or town, state) <u>Hagerstown, W. Va.</u> DATE SIGNED <u>Nov 4/58</u>	
PHYSICIAN'S NAME (Type) <u>J. W. Beechey</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 5-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf</u> ADDRESS <u>Wilkompo, Maryland</u>		24a. REC'D BY REGISTRAR <u>NOV 6 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hous</u>

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 1920

## CERTIFICATE OF DEATH

*Robert L. Williams, Mayor*

Reg. Dist. No. 12990

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>8 Hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Boonsboro</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>81 Washington County Hospital</b>				d. STREET ADDRESS <b>112 Potomac Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>THOMAS LAWRENCE COULTER</b>				4. DATE OF DEATH Month Day Year <b>November 6 1958 19</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 6 1958</b>	
9. AGE (In years last birthday) yrs. <b>3</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>3 0 0 0</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown Wash. Co. Md. U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward W. Coulter</b>				14. MOTHER'S MAIDEN NAME <b>Ruby May Breeden</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Edward W. Coulter Boonsboro Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity</b> <b>776x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Premature Labor</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						INTERVAL BETWEEN ONSET AND DEATH <b>h.s.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-6-58</b> , 19 <b>58</b> , to <b>11-6-58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11-6-58</b> , 19 <b>58</b> , and that death occurred at <b>119 E. Anticipation</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Louis G. Glott</b> M.D. <b>11/8/58</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>Louis G. Glott</b> <b>Hagerstown Md</b>							
22a. REMOVAL, CREMATION, BURIAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 8 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Boonsboro Wash. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Bass</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 12 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12345

<p>NAME OF DECEASED                  JAMES H. HARRIS</p>		<p>AGE                  65 Years</p>		<p>SEX                  Male</p>	
<p>DATE OF DEATH                  November 1, 1955</p>		<p>TIME OF DEATH                  10:30 A.M.</p>		<p>PLACE OF DEATH                  Home</p>	
<p>CAUSE OF DEATH                  Myocardial Infarction</p>		<p>IMMEDIATE CAUSE                  Coronary Thrombosis</p>		<p>UNDERLYING CAUSE                  Atherosclerosis</p>	
<p>DATE OF BIRTH                  November 1, 1890</p>		<p>PLACE OF BIRTH                  Baltimore, Md.</p>		<p>EDUCATION                  High School Graduate</p>	
<p>OCCUPATION                  Retired</p>		<p>RELIGION                  Roman Catholic</p>		<p>US BIRTH                  Yes</p>	
<p>DATE OF MARRIAGE                  May 15, 1915</p>		<p>NAME OF SPOUSE                  Mary E. Harris</p>		<p>DATE OF LAST VISIT                  October 25, 1955</p>	
<p>DATE OF INTERMENT                  November 5, 1955</p>		<p>PLACE OF INTERMENT                  St. Ignace Cemetery</p>		<p>NAME OF FUNERAL HOME                  J. J. Harris &amp; Son</p>	
<p>DATE OF SIGNATURE                  November 1, 1955</p>		<p>SIGNATURE OF PHYSICIAN                  J. J. Harris</p>		<p>SIGNATURE OF REGISTRAR                  J. J. Harris</p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12993 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12991

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 132 Nottingham Road		e. STREET ADDRESS 132 Nottingham Road	
3. NAME OF DECEASED (Type or print) ELAINE GARNET CRAIG		4. DATE OF DEATH Nov. 25 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1958
9. AGE (in years last birthday) yrs. 5 20		10. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Ollen O. Craig		14. MOTHER'S MAIDEN NAME Lillian Marquiss	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. O. O. Craig		Address 132 Nottingham Road Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Confluent lobular pneumonia right middle lobe DUE TO lung; right & left lower lobes Conditions, if any, which gave rise to immediate cause (b) Acute suppurative synovitis left elbow joint (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		INTERVAL BETWEEN ONSET AND DEATH ?	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/28/58	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE REC 1 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

100038 xv

1921 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
DISEASE OR INJURY: [illegible]  
LOCALITY: [illegible]  
OCCUPATION: [illegible]  
EDUCATION: [illegible]  
RELIGION: [illegible]  
MARRIAGE: [illegible]  
CHILDREN: [illegible]  
SIBLINGS: [illegible]  
PARENTS: [illegible]  
GRANDPARENTS: [illegible]  
BROTHERS: [illegible]  
SISTERS: [illegible]  
Aunts: [illegible]  
Uncles: [illegible]  
Nephews: [illegible]  
Nieces: [illegible]  
Cousins: [illegible]  
In-laws: [illegible]  
Other relatives: [illegible]  
Social history: [illegible]  
Hobbies: [illegible]  
Drugs: [illegible]  
Alcohol: [illegible]  
Tobacco: [illegible]  
Mental history: [illegible]  
Physical history: [illegible]  
Family history: [illegible]  
Genetic history: [illegible]  
Environmental history: [illegible]  
Occupational history: [illegible]  
Travel history: [illegible]  
Military history: [illegible]  
Criminal history: [illegible]  
Civil history: [illegible]  
Financial history: [illegible]  
Legal history: [illegible]  
Medical history: [illegible]  
Surgical history: [illegible]  
Dental history: [illegible]  
Ophthalmological history: [illegible]  
Otorhinolaryngological history: [illegible]  
Gynecological history: [illegible]  
Urological history: [illegible]  
Neurological history: [illegible]  
Psychiatric history: [illegible]  
Endocrinological history: [illegible]  
Immunological history: [illegible]  
Hematological history: [illegible]  
Histopathological history: [illegible]  
Microbiological history: [illegible]  
Parasitological history: [illegible]  
Radiological history: [illegible]  
Laboratory history: [illegible]  
Other: [illegible]

Signature of Medical Examiner: [illegible]  
Signature of Coroner: [illegible]  
Signature of Registrar: [illegible]  
Signature of Attorney: [illegible]  
Signature of Minister: [illegible]  
Signature of Priest: [illegible]  
Signature of Rabbi: [illegible]  
Signature of Imam: [illegible]  
Signature of Other: [illegible]

Witnesses: [illegible]  
Notary Public: [illegible]  
Date: [illegible]  
Place: [illegible]



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - Washington County Hospital</u>		d. STREET ADDRESS <u>28 Glenside Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES ROBERTSON CUDDY Jr</u>		4. DATE OF DEATH Month Day Year <u>November 15 1958 19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 30 1917</u>
9. AGE (In years) <u>41</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W.M.R.R. Klotz Giles Co Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James R. Cuddy Sr</u>		14. MOTHER'S MAIDEN NAME <u>Reba Atkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W.# 2 705-10-7735</u>	
17. INFORMANT <u>Mrs Janet R. Cuddy</u>		Address <u>28 Glenside Ave Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound thru chest and heart (.22 bullet)</u> <u>981X</u> DUE TO Hemorrhage and shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot thru chest and heart with a .22 automatic pistol</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>3:50</u> <u>PM</u> <u>Nov. 15 1958</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) (County) (State) <u>Hagerstown Wash Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/18/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



1

M

81

I

0

1

VS A15 (4)  
15M 9/55

2091234XV0

12995

12993

Reg. Dist. No.

12995

CERTIFICATE OF DEATH

1. PLACE OF DEATH  
o. COUNTY Washington MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown

c. LENGTH OF STAY IN 1b 1 hour

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
o. STATE Md. b. COUNTY Wash

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown, Maryland

3. NAME OF DECEASED (Type or print) First Middle Last DeHart

4. DATE OF DEATH Nov. 13, 1958 19

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH Nov. 13, 1958 9. AGE (In years last birthday) yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min. 1

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Zebulon DeHart 14. MOTHER'S MAIDEN NAME Novell Nancy Swain

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Immaturity 761.5 DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Premature separation of placenta DUE TO  
(c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ INTERVAL BETWEEN ONSET AND DEATH 57 minutes

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED White ☐ Not white ☐ of work ☐ at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 13, 1958, to November 13, 1958, that I last saw the deceased alive on November 13, 1958, and that death occurred at 5:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE Sidney Noveste M.D. ADDRESS (Street, city or town, state) DATE SIGNED

PHYSICIAN'S NAME (Type) SIDNEY NOVESTE, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 22b. DATE THEREOF 11/13/58 22c. NAME OF CEMETERY OR CREMATORY Wash. County Hospital 22d. LOCATION (City, town, or county) (State) Hagerstown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR DATE NOV 17 '58 24b. REGISTRAR'S SIGNATURE Arthur S. Knapp



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 10/57

12996

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 236 11-28-58 et

CERTIFICATE OF DEATH

12994

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u>				c. LENGTH OF STAY IN 1b <u>3 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>R</u> Last <u>Delauter</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 22 1924</u>	9. AGE (In years lost birthday) <u>33</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>28</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Store Stickell's (Feed)</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John Delauter</u>				14. MOTHER'S MAIDEN NAME <u>Beulah Bryder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>220 16 1125</u>			
17. INFORMANT <u>Mrs. Gloris Delauter</u>				Address <u>Williamsport Md. RD #1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> <u>584X</u> DUE TO <u>follows: cholelithiasis, chronic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>cholelithiasis</u> DUE TO (c) <u>cholelithiasis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 yr.</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>10/27/58</u> to <u>Nov. 20/58</u> , that I last saw the deceased alive on <u>Nov. 20/58</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip J. Hirshman</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>11/21/58</u>			
PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>				M.D. <u>159 W. Washington St. Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Nov. 22-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf Williamsport Md</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
22d. LOCATION (City, town, or county) <u>Williamsport Maryland</u>				22e. (State) <u>Maryland</u>			

4





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12997

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12995

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>406 BROOKLINE AVE.</b>			d. STREET ADDRESS <b>406 BROOKLINE AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>HARRY HOWARD DIBERT</b>			4. DATE OF DEATH Month Day Year <b>NOV. 12 1958</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/18/1896</b>	9. AGE (In years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <b>62</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CARPENTER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION CO. MARYLAND</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>
13. FATHER'S NAME <b>HENRY C. DIBERT</b>			14. MOTHER'S MAIDEN NAME <b>AMY K. CLOPPER</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-09-1126</b>		17. INFORMANT Address <b>MRS. AMY B. RICE HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Alcoholism</b> <b>322.1</b> DUE TO <b>Acute Alcoholic narcosis</b> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>none 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	
20f. (City or town) <b>-</b>		20g. (County) <b>-</b>		20h. (State) <b>-</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>11-17-58</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/17/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FUNKSTOWN CEM.</b>	
22d. LOCATION (City, town, or county) <b>FUNKSTOWN MD.</b>		22e. (State) <b>MD.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment, Hagerstown, Md.</b>		ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 19 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>Orlando A. ...</b>					

FOR STATE  
HEALTH OFF.

DEPT. OF HEALTH

STATE OF NEW YORK

HEALTH OFF.

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

13039

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro, RFD, Md.</u>				c. LENGTH OF STAY IN 1b <u>13 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Keedy - Fahrney Memorial Home</u>				e. STREET ADDRESS <u>1 Randolph Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth Kitzmiller Dunn</u>				4. DATE OF DEATH <u>Nov. 25, 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28, 1866</u>		9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Keedysville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frisby Kitzmiller</u>				14. MOTHER'S MAIDEN NAME <u>RoseAnn Willett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Clyde Spangler, 858 Virginia Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>with chronic myocardide</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 10, 1958</u> , to <u>Nov 25, 1958</u> , that I last saw the deceased alive on <u>Nov 25, 1958</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. W. Lellan</u> M.D.				ADDRESS (Street, city or town, state) <u>Boonsboro, Md.</u>			
PHYSICIAN'S NAME (Type) <u>G. W. Lellan</u>				DATE SIGNED <u>11/26/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. K. Coffman</u> ADDRESS <u>Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. For this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

A. E. Collins, Hays town, Mo.

13040

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO</b>				c. LENGTH OF STAY IN 1b <b>LIFE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>McKELDEN DRIVE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM H. EASTERDAY</b>				4. DATE OF DEATH Month Day Year <b>NOVEMBER 22 1958 19</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1871</b> <b>JUNE 24 1878</b>	9. AGE (In years last birthday) <b>87</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>		11. BIRTHPLACE (State or foreign country) <b>BOONSBORO WASH.CO.MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHRISTIAN EASTERDAY</b>				14. MOTHER'S MAIDEN NAME <b>AMANDA HOUP</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>MRS. LLOYD LOHMAN BOONSBORO MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>450.0</b> IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>2920</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 6</b> , 19 <b>58</b> , to <b>Nov 22</b> , 19 <b>58</b> that I last saw the deceased alive on <b>March 19 58</b> , and that death occurred at <b>3:40 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. W. Lohman</b>				ADDRESS (Street, city or town, state) <b>Boonsboro Md</b>		DATE SIGNED <b>11/24/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>NOV. 25 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>LUTHERAN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MIDDLETOWN FRED.CO.MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John C. Bass</b>				ADDRESS <b>Boonsboro Md</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 26 1958</b>	
				24b. REGISTRAR'S SIGNATURE <b>Conrad S. Francis</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







13041

## CERTIFICATE OF DEATH

12998

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>W. Va.</u> b. COUNTY <u>Morgan</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown Md.</u>		c. LENGTH OF STAY IN 1b <u>4 Mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Rest Home</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Paw Paw, 85 x -3</u>	
3. NAME OF DECEASED (Type or print) <u>MOLLY McCOOLE EASTON</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 16, 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>----</u>	9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months <u>11</u> Days <u>18</u> Hours <u>---</u> Min. <u>---</u>
11. BIRTHPLACE (State or foreign country) <u>Paw Paw, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>S. D. Moser</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Largent</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Chas. E. Easton,</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infection of old injury to left hip.</u> 962X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chr. Endocarditis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>6 mo.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 10, 1958, to Nov. 4, 1958</u> , that I last saw the deceased alive on <u>Nov. 3, 1958</u> , and that death occurred at <u>1 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.		ADDRESS (Street, city or town, state) <u>Clear Spring Md.</u> DATE SIGNED <u>10/4/58</u>	
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>II/7/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Camp Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Paw Paw, W. Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Berkeley Springs, W. Va.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 7 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. H.</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF CLERK</p>		<p>16. SIGNATURE OF JUDGE</p>	
<p>17. SIGNATURE OF SHERIFF</p>		<p>18. SIGNATURE OF CORONER</p>		<p>19. SIGNATURE OF JURY</p>		<p>20. SIGNATURE OF COURT</p>	
<p>21. SIGNATURE OF STATE</p>		<p>22. SIGNATURE OF COUNTY</p>		<p>23. SIGNATURE OF CITY</p>		<p>24. SIGNATURE OF TOWNSHIP</p>	
<p>25. SIGNATURE OF VILLAGE</p>		<p>26. SIGNATURE OF WARD</p>		<p>27. SIGNATURE OF BLOCK</p>		<p>28. SIGNATURE OF LOT</p>	
<p>29. SIGNATURE OF SECTION</p>		<p>30. SIGNATURE OF RANGE</p>		<p>31. SIGNATURE OF MERIDIAN</p>		<p>32. SIGNATURE OF TOWNSHIP</p>	
<p>33. SIGNATURE OF COUNTY</p>		<p>34. SIGNATURE OF STATE</p>		<p>35. SIGNATURE OF UNION</p>		<p>36. SIGNATURE OF WORLD</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

13042

13042

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12999

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrotts Mills</b>		c. LENGTH OF STAY IN 1b <b>1 year</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Garrotts Mills</b>	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Frederick Harrison Edwards</b>		4. DATE OF DEATH Month Day Year <b>11 27 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-27-1895</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sargent Police</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fairchild Corp.</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John George Edwards</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Virginia Mills</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. William E. Kidwell, Knoxville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart disease</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Kenneth C. Henson</b> M.D.		ADDRESS (Street, city or town, state) <b>Middletown, Md.</b>	
DATE SIGNED <b>11/28/58</b>			
PHYSICIAN'S NAME (Type) <b>Kenneth C. Henson</b>		<b>Middletown Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-30-1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Brethern</b>		22d. LOCATION (City, town, or county) (State) <b>Brownsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Lee Fort</b>		ADDRESS <b>Brunswick, Maryland</b>	
24a. REC'D BY REGISTRAR <b>DEC 2 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hines</b>	

2004

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13043

CERTIFICATE OF DEATH

13000

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NEAR HAGERSTOWN</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GATE WAY NURSING HOME</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO</b> d. STREET ADDRESS <b>ST. PAUL STREET EXTENDED</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES OGDEN ELLIOTT</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 24 1958 19</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 9 1882</b>
9. AGE (In years lost birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>	
11. BIRTHPLACE (State or foreign country) <b>LOCKHART COVE VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES MADISON ELLIOTT</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA TRIPPLETT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>ROSBIA ELLIOTT BOONSBORO MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Heart Dis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 10, 1958</b> to <b>Nov 24, 1958</b> , that I lost sows the deceased alive on <b>Nov 22, 1958</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>David R. Brewer</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>Clear Spring Md. 11/24/58</b>	
PHYSICIAN'S NAME (Type) <b>David R. Brewer</b>		M.D.	
22a. BURIAL, CREMATION, REINTERMENT <b>BURIAL</b>		22b. DATE THEREOF <b>NOV. 27 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>GREEN HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BERRVILLE VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Best</b>		ADDRESS <b>Boonsboro Md</b>	
24a. REC'D BY REGISTRAR <b>NOV 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION







TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

13044 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13001

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FUNKSTOWN</b>				c. LENGTH OF STAY IN 1b <b>30 YEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>12 FREDERICK ROAD</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>V</b> Last <b>FISHER</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>6</b> Year <b>1958</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 3 1889</b>		9. AGE (In years last birthday) <b>69</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BENEVOLA WASH.CO.MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES H. KLINE</b>				14. MOTHER'S MAIDEN NAME <b>LYDIA E. FAHRNEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>CHARLES W. FISHER FUNKSTOWN MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease.</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinson's Syndrome</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Months.</b> <b>Years.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 3 1958</b> , to <b>November 6 1958</b> , that I last saw the deceased alive on <b>November 5, 1958</b> and that death occurred at <b>11-P-M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>119 North Potomac St. Hagerstown, Maryland.</b> DATE SIGNED <b>Nov. 8, 1958</b>							
ACTUAL SIGNATURE <b>R.A. Bell, M.D.</b>		M.D. <b>119 North Potomac St. Hagerstown, Maryland.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>NOV. 9 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MOUNTAIN VIEW CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>SHARPSBURG WASH.CO.MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. East</b>				ADDRESS <b>Boonsboro Md</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 12 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinas</b>			

MEDICAL CERTIFICATION

0

Dr. Bell  
9-21-40

I



13045

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clearspring</u>		c. LENGTH OF STAY IN 1b <u>15 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Barry</u> Last <u>Frank</u>		4. DATE OF DEATH Month <u>11</u> Day <u>10</u> Year <u>19 58</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 26, 1866</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John David Frank</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Betz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Archie R. Cohen</u>		Address <u>Clearspring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery occlusion with myocardial infarction 1 hour</u> DUE TO (c) <u>Hypertensive arteriosclerotic heart disease</u> unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 07</u> , 19 <u>58</u> , to <u>Nov. 10</u> , 19 <u>58</u> that I last saw the deceased alive on <u>Nov. 10</u> , 19 <u>58</u> , and that death occurred at <u>10:45 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Clearspring, Md.</u> DATE SIGNED <u>11/4/58</u>			
ACTUAL SIGNATURE <u>Ralph E. Young</u> M.D.		PHYSICIAN'S NAME (Type) <u>William F. Clark</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11/15/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rienzi Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fond du Lac Wisc.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Clark</u> ADDRESS <u>Clearspring, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 13 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13003

12998

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>34 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Pauline</b> Middle <b>V</b> Last <b>Gearhart</b>		4. DATE OF DEATH Month <b>11</b> Day <b>10</b> Year <b>19 58</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 1, 1915</b>
9. AGE (In years last birthday) <b>43</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Alexander Hotel</b>	
11. BIRTHPLACE (State or foreign country) <b>Williamsport, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Allen Gearhart</b>		14. MOTHER'S MAIDEN NAME <b>Ella Hoffman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> no <input type="checkbox"/> yes, give war or date of service		16. SOCIAL SECURITY NO. <b>220-18-1608</b>	
17. INFORMANT <b>Harold Gearhart</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Abscess</b> DUE TO (c) <b>Carcinoma of bronchus</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>?</b> <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10 Oct</b> , 19 <b>58</b> , to <b>10 Nov</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9 Nov</b> , 19 <b>58</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>115 W. Wash. St. Hagerstown, Md.</b> DATE SIGNED <b>Nov 10 58</b> ACTUAL SIGNATURE <b>Edwin D. Huachlander</b> PHYSICIAN'S NAME (Type) <b>Edwin D. Huachlander</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>11-13-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Rural Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>NOV 12 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraiss</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12999

CERTIFICATE OF DEATH

Reg. Dist. No.

13004

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>50 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1689 Salem Ave. extd.</u>		e. STREET ADDRESS <u>1689 Salem Ave. Extd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Iva</u> Middle <u>Belle</u> Last <u>Golden</u>		4. DATE OF DEATH Month <u>11</u> Day <u>22</u> Year <u>58</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28, 1893</u>
9. AGE (In years lost birthday) yrs. <u>65</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Clearspring, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Drury</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Forsythe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-16-1942</u>	
17. INFORMANT <u>Irvin Golden</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Head of Pancreas</u> <u>157x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 21, 1958</u> , to <u>May 22, 1958</u> , that I last saw the deceased alive on <u>May 21, 1958</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. F. Lusby</u>		ADDRESS (Street, city or town, state) <u>2301 Pomeroy St Hagerstown Md.</u>	
PHYSICIAN'S NAME (Type) <u>F. F. Lusby</u>		DATE SIGNED <u>24th 58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>11-25-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Kraiss</u>		ADDRESS <u>Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraiss</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13005

13000

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 mo. 7 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jackson Convalescent Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>VIOLA</u> Last <u>GREENAWALT</u>				4. DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 9, 1877</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Near Springfield, Ill.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Mitchell Pensinger</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Burger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>George Greenawalt</u> Address <u>Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>174X</u> IMMEDIATE CAUSE (a) <u>Cancer of Uterus</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>5 mo</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>58</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept 3, 1958</u> to <u>Nov 10, 1958</u> , that I last saw the deceased alive on <u>Nov 10, 1958</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sidney Novenstein</u> M.D.				ADDRESS (Street, city or town, state) <u>2 Lakeside Dr</u> DATE SIGNED <u>11-11-58</u>			
PHYSICIAN'S NAME (Type) <u>SIDNEY NOVENSTEIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/13/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Greencastle, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Berger</u> ADDRESS <u>Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

100

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13006

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>44 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>630 George St.,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>C</u> Last <u>Harbaugh</u>		4. DATE OF DEATH Month <u>11</u> Day <u>4</u> Year <u>19 58</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 29, 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Bishop</u>		14. MOTHER'S MAIDEN NAME <u>Lula Wetzel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Allen A Harbaugh</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic myocardial heart disease</u> DUE TO <u>Vascular hypertension</u> Conditions, if any, which gave rise to immediate cause (b) <u>Acute Coronary occlusion</u> (c) <u>  </u> DUE TO <u>  </u> cause lost. <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes M</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>none</u> 19 p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11-4-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11-7-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Kraiss</u>		ADDRESS <u>Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

13046 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 16 Film G235 11-18-58 et  
CERTIFICATE OF DEATH

13007

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Conococheague 4 Mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u> 75 x 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Convalescent Home</u>		d. STREET ADDRESS <u>220 W. Balto. ST.</u>	
3. NAME OF DECEASED (Type or print) <u>MABEL</u> First <u>A.</u> Middle <u>HEININGER</u> Last		4. DATE OF DEATH <u>Nov.</u> Month <u>10,</u> Day <u>1958</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 4 1897</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Antrim Twp., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel H. Goldsmith</u>		14. MOTHER'S MAIDEN NAME <u>Frances Staley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>185-10-2903</u>	
17. INFORMANT <u>Ray K. Henninger</u> Address <u>Funkstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Dis.</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 7, 1958</u> , to <u>Nov 10, 1958</u> , that I last saw the deceased alive on <u>Nov. 9, 1958</u> , and that death occurred at <u>4:30 A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David R. Brewer M.D.</u>		ADDRESS (Street, city or town, state) <u>Clear Spring Md.</u> DATE SIGNED <u>11/11/58</u>	
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-12-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Greencastle, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Minnich</u> ADDRESS <u>Greencastle, Pa.</u>		24a. REC'D BY REGISTRAR <u>NOV 13 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - JANUARY ONE, 19

1948

PLACE OF DEATH

HOSPITAL

NAME OF DECEASED

AGE

DATE OF DEATH

DATE

OF

DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

DATE OF DEATH

PLACE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13002

## CERTIFICATE OF DEATH

13008

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>4 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>637 George Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Wenk</u> Middle <u>Shipley</u> Last <u>Henson</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>12</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4 1901</u>	
9. AGE (In years last birthday) yrs. <u>57</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>7</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ribbon Finisher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Md. Ribbon Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Frank Henson</u>				14. MOTHER'S MAIDEN NAME <u>Annie Fowler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>220 09 9477</u>		17. INFORMANT <u>Mrs. Mary Henson</u> Address <u>637 George Street Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/11/58</u> , 19 <u>58</u> , to <u>11/12/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/12/58</u> , 19 <u>58</u> , and that death occurred at <u>1 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hagerstown Md.</u> DATE SIGNED <u>11/13/58</u> ACTUAL SIGNATURE <u>Ralph E. Young</u> M.D. PHYSICIAN'S NAME (Type) <u>William S. H. Young</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 14-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mennonite Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pinesburg Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Alfred Lee Williams</u> ADDRESS <u>Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hynes</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1900

ALFRED  
BROWN

NAME	ALFRED BROWN
AGE	45
SEX	Male
RACE	White
DATE OF BIRTH	Jan 15 1855
PLACE OF BIRTH	Worcester, Mass.
DATE OF DEATH	Dec 10 1900
PLACE OF DEATH	Worcester, Mass.
Cause of Death	Heart Disease
Signature of Physician	[Signature]
Signature of Registrar	[Signature]

13003

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>6 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Memorial Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HARRIE</u> Middle <u>JOEL</u> Last <u>HOLLINGSWORTH</u>				4. DATE OF DEATH Month <u>November</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 29 1861</u>	9. AGE (In years last birthday) <u>97</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manufacturer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Wheel Harford Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Joel C. Hollingsworth</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Carter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Webster P. Hollingsworth</u> Address <u>640 Summit Ave Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General arteriosclerosis with</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral thrombosis</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign prostatic hypertrophy</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Nov. 18, 1958</u> , to <u>Nov. 18, 1958</u> , that I last saw the deceased alive on <u>Nov. 18, 1958</u> , and that death occurred at <u>5:28</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edmund W. Dittmann</u> M.D. <u>212 W. Washington St</u>				DATE SIGNED <u>11/19/58</u>			
PHYSICIAN'S NAME (Type) <u>  </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/20/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery Hagerstown Wash. Co Md.</u>		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Friend</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**13004 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

13010

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Clearspring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DOA - Emergency Room-Hospital</b>				f. STREET ADDRESS <b>R # 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Michael</b> Middle <b>S</b> Last <b>Horst</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>1</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 10, 1886</b>		9. AGE (in years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maugansville, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Abraham Horst</b>				14. MOTHER'S MAIDEN NAME <b>Fannie Strite</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-28-5877</b>		17. INFORMANT Address <b>Mrs. Florence Horst - R # 1 Clearspring, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Coronary Heart disease</b> <b>420.1</b> DUE TO <b>Acute Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>None 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>S. Robert Wells</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-5-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Clearspring Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Clearspring, Wash, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. E. Minnich</b>				ADDRESS <b>Greencastle, Pa.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 6 '58</b>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. House</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1900 - MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
 NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

Name of Deceased [Illegible]		Date of Death [Illegible]	
Age of Deceased [Illegible]		Sex of Deceased [Illegible]	
Race of Deceased [Illegible]		Color of Deceased [Illegible]	
Marital Status [Illegible]		Occupation [Illegible]	
Usual Residence [Illegible]		Place of Death [Illegible]	
Cause of Death [Illegible]		Manner of Death [Illegible]	
Signature of Medical Examiner [Illegible]		Signature of Coroner [Illegible]	
Date of Examination [Illegible]		Time of Examination [Illegible]	

13047

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>W. Va.</u> b. COUNTY <u>Keyser</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>3 Weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ethel</u> First Middle Last <u>Huffman</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 25, 1880</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>15</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David L Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn Constable</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Marie Evans Moorefield W. Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac and Respiratory arrest</u> DUE TO <u>331x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular accident</u> DUE TO <u>?</u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 7</u> , 19 <u>58</u> , to <u>Nov 10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 10</u> , 19 <u>58</u> , and that death occurred at <u>11:40 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M Byrkit</u>				ADDRESS (Street, city or town, state) <u>28 W. PETER MAC ST</u>			
PHYSICIAN'S NAME (Type) <u>Max Byrkit</u>				DATE SIGNED <u>William Sport, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 13-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Queens Point Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Keyser W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Hoffman Jr. Martinsburg, W. Va.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JIM BOND

CERTIFICATE OF DEATH

ILLINOIS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NAME OF DECEASED		JIM BOND	
DATE OF DEATH		JAN 10 1922	
PLACE OF DEATH		CHICAGO, ILL.	
AGE		37	
SEX		MALE	
RACE		WHITE	
OCCUPATION		LABORER	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		[Signature]	
SIGNATURE OF REGISTRAR		[Signature]	
OFFICIAL SEAL		[Seal]	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13005 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13012

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Rural R # 6</b> <b>Hagerstown</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. Washington County Hospital</b>			d. STREET ADDRESS <b>1</b> -----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>EDMOND</b> Last <b>JACKSON</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>5</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 3, 1899</b>		9. AGE (In years last birthday) <b>59</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fairchild Aircraft</b>		11. BIRTHPLACE (State or foreign country) <b>Mapleville Wash. Co. Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Charles Jackson</b>			14. MOTHER'S MAIDEN NAME <b>Cora Griffith</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-10-3853</b>		17. INFORMANT Address <b>Mrs. J.E. Jackson R # 6 Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Advanced Arteriosclerotic coronary heart disease</b> <b>420.1</b> DUE TO <b>Vascular hypertension</b> Conditions, if any, which gave rise to immediate cause (b) <b>Acute Coronary thrombosis</b> (c) <b>Acute Cardiac tamponade</b> cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>	
		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>11-6-58</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/8/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	
				22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>			24a. REC'D BY REGISTRAR <b>NOV 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





13006

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <u>03 Hagerstown</u>			
c. LENGTH OF STAY IN 1b <u>De O. A.</u>				d. STREET ADDRESS <u>/ Hotel Hamilton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LEO</u> Middle <u>DONALD</u> Last <u>JAMES</u>				4. DATE OF DEATH Month <u>November</u> Day <u>27</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19, 1906</u>		9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>Port Huron, Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph James</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs Edna James Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cholelithiasis</u> <u>322.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>one week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>11/27/58</u>			
EXAMINER'S NAME (Type) <u>J. E. W. J. T. T. J.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/29/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u> <u>R. Franklin Rager</u>				24a. REC'D BY REGISTRAR <u>DEC 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF TEXAS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. COLOR		6. BIRTH DATE	
7. BIRTH PLACE		8. MARRIAGE DATE		9. MARRIAGE PLACE	
10. DECEASED DATE		11. DECEASED TIME		12. DECEASED PLACE	
13. DECEASED CAUSE		14. DECEASED MANNER		15. DECEASED DISEASE	
16. DECEASED INJURY		17. DECEASED WEAPON		18. DECEASED WEAPON TYPE	
19. DECEASED WEAPON LOCATION		20. DECEASED WEAPON TYPE		21. DECEASED WEAPON TYPE	
22. DECEASED WEAPON TYPE		23. DECEASED WEAPON TYPE		24. DECEASED WEAPON TYPE	
25. DECEASED WEAPON TYPE		26. DECEASED WEAPON TYPE		27. DECEASED WEAPON TYPE	
28. DECEASED WEAPON TYPE		29. DECEASED WEAPON TYPE		30. DECEASED WEAPON TYPE	
31. DECEASED WEAPON TYPE		32. DECEASED WEAPON TYPE		33. DECEASED WEAPON TYPE	
34. DECEASED WEAPON TYPE		35. DECEASED WEAPON TYPE		36. DECEASED WEAPON TYPE	
37. DECEASED WEAPON TYPE		38. DECEASED WEAPON TYPE		39. DECEASED WEAPON TYPE	
40. DECEASED WEAPON TYPE		41. DECEASED WEAPON TYPE		42. DECEASED WEAPON TYPE	
43. DECEASED WEAPON TYPE		44. DECEASED WEAPON TYPE		45. DECEASED WEAPON TYPE	
46. DECEASED WEAPON TYPE		47. DECEASED WEAPON TYPE		48. DECEASED WEAPON TYPE	
49. DECEASED WEAPON TYPE		50. DECEASED WEAPON TYPE		51. DECEASED WEAPON TYPE	
52. DECEASED WEAPON TYPE		53. DECEASED WEAPON TYPE		54. DECEASED WEAPON TYPE	
55. DECEASED WEAPON TYPE		56. DECEASED WEAPON TYPE		57. DECEASED WEAPON TYPE	
58. DECEASED WEAPON TYPE		59. DECEASED WEAPON TYPE		60. DECEASED WEAPON TYPE	
61. DECEASED WEAPON TYPE		62. DECEASED WEAPON TYPE		63. DECEASED WEAPON TYPE	
64. DECEASED WEAPON TYPE		65. DECEASED WEAPON TYPE		66. DECEASED WEAPON TYPE	
67. DECEASED WEAPON TYPE		68. DECEASED WEAPON TYPE		69. DECEASED WEAPON TYPE	
70. DECEASED WEAPON TYPE		71. DECEASED WEAPON TYPE		72. DECEASED WEAPON TYPE	
73. DECEASED WEAPON TYPE		74. DECEASED WEAPON TYPE		75. DECEASED WEAPON TYPE	
76. DECEASED WEAPON TYPE		77. DECEASED WEAPON TYPE		78. DECEASED WEAPON TYPE	
79. DECEASED WEAPON TYPE		80. DECEASED WEAPON TYPE		81. DECEASED WEAPON TYPE	
82. DECEASED WEAPON TYPE		83. DECEASED WEAPON TYPE		84. DECEASED WEAPON TYPE	
85. DECEASED WEAPON TYPE		86. DECEASED WEAPON TYPE		87. DECEASED WEAPON TYPE	
88. DECEASED WEAPON TYPE		89. DECEASED WEAPON TYPE		90. DECEASED WEAPON TYPE	
91. DECEASED WEAPON TYPE		92. DECEASED WEAPON TYPE		93. DECEASED WEAPON TYPE	
94. DECEASED WEAPON TYPE		95. DECEASED WEAPON TYPE		96. DECEASED WEAPON TYPE	
97. DECEASED WEAPON TYPE		98. DECEASED WEAPON TYPE		99. DECEASED WEAPON TYPE	
100. DECEASED WEAPON TYPE		101. DECEASED WEAPON TYPE		102. DECEASED WEAPON TYPE	

*Count Chabon*

*on work*

*Dr. J. T. W. J.*  
*10.11.11*

*11/2/11*

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

15015

13014  
303

13007

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>12 Weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROSA</u> Middle <u>-----</u> Last <u>KAPLAN</u>		4. DATE OF DEATH Month <u>November</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 4 1877</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>----- Rosen</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Ellik Kaplan 702 Marshall St</u>		Address <u>Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Inanition</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Retroperitoneal abscess due to perforated colon</u> (c) <u>Adenocarcinoma rectum</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>5 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, generalized; hypertension severe</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-3</u> , 19 <u>58</u> to <u>11-28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11-27</u> , 19 <u>58</u> , and that death occurred at <u>3:06 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Kehne</u>		DATE SIGNED <u>131 West Washington St. Hagerstown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>John H. Kehne M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/30/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>B'Nai Abraham Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

Item 18 Film 236 11-26-58 ans

13008

13015

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Co. Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
		f. STREET ADDRESS <u>227 E. Franklin St.,</u>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Alan</u> Last <u>Knode</u>		4. DATE OF DEATH Month <u>11</u> Day <u>7</u> Year <u>19 58</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3, 1958</u>
9. AGE (In years last birthday) yrs. <u>4</u> Months <u>4</u> Days <u>4</u>		IF UNDER 1 YEAR Hours <u>4</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James A. Knode</u>		14. MOTHER'S MAIDEN NAME <u>Shirley M. Walls</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>James A. Knode</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Virus pneumonitis; congenital hypoplasia</u> <u>759.3</u> DUE TO <u>adrenal glands; Hemorrhage into lungs,</u> Conditions, if any, which gave rise to immediate cause (b) <u>myocardium and thymus.</u> (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>None</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>		20f. (City or town) (County) (State) <u>- - -</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>Nov. 9 '58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11-10-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Kraiss</u>		ADDRESS <u>Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 12 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hesser</u>	

2081223XV4







CERTIFICATE OF DEATH

1900

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES M. JONES		45		M		W		1855		MISSISSIPPI		MEMPHIS		SHARP		MISSISSIPPI	
FATHER'S NAME		MOTHER'S NAME		MARRIED		SINGLE		WIDOW		DIVORCED		RE-MARRIED		OTHER			
JAMES M. JONES		MARY J. JONES		M		F		1855		MISSISSIPPI		MEMPHIS		SHARP		MISSISSIPPI	
DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		DATE OF INTERMENT		PLACE OF INTERMENT		CITY		COUNTY	
1900		MEMPHIS		MEMPHIS		SHARP		MISSISSIPPI		1900		MEMPHIS		MEMPHIS		SHARP	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		PHYSICIAN		NURSE		BAPTIST		OTHER	
HEART DISEASE		NATURAL		HEART DISEASE		HEART DISEASE		HEART DISEASE		DR. J. M. JONES		MISSISSIPPI		MISSISSIPPI		MISSISSIPPI	
DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		DATE OF INTERMENT		PLACE OF INTERMENT		CITY		COUNTY	
1900		MEMPHIS		MEMPHIS		SHARP		MISSISSIPPI		1900		MEMPHIS		MEMPHIS		SHARP	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		PHYSICIAN		NURSE		BAPTIST		OTHER	
HEART DISEASE		NATURAL		HEART DISEASE		HEART DISEASE		HEART DISEASE		DR. J. M. JONES		MISSISSIPPI		MISSISSIPPI		MISSISSIPPI	

13010

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>20 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>6 Suters Alley</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Kraft</u> Last <u>Kraft</u>		4. DATE OF DEATH Month <u>11</u> Day <u>29</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8-22-1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Kraft</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Calimer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Laura Davis</u>		Address <u>Baltimore, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Auricular Fibrillation - Chronic Pulmonary Fibrosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>11</u> p. m. <u>20</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/20</u> , 19 <u>58</u> , to <u>11/28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/28/58</u> , 19 <u>58</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. D. Valen</u>		ADDRESS (Street, city or town, state) <u>135 NO. POTOMAC ST. HAGERSTOWN, MARYLAND</u>	
PHYSICIAN'S NAME (Type) <u>J. D. VALEN, M.D.</u>		DATE SIGNED <u>12/1/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>12-2-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Kraiss</u>		ADDRESS <u>Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur A. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

---

13011

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> 03			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>716 Summit Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ESTHER</u> Middle <u>B</u> Last <u>LEFEVER</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>6</u> Year <u>1958</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 7, 1901</u>		9. AGE (In years lost birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>29</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles S. Baker</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Shifler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Samuel H. Lefever</u>		Address <u>716 Summit Ave. Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RETROPERITONEAL ABSCESS</u> <u>572.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DIVERTICULITIS</u> DUE TO (c) <u>1 year</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-26</u> , 19 <u>58</u> , to <u>11-6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11-6-58</u> , 19 <u>58</u> , and that death occurred at <u>11:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>318 N. Potomac St. Hagerstown, Md.</u> DATE SIGNED <u>11-7-58</u>							
ACTUAL SIGNATURE <u>Paul Harrison</u> M.D. <u>318 N. Potomac St.</u>				DATE SIGNED <u>11-7-58</u>			
PHYSICIAN'S NAME (Type) <u>Paul Harrison, M. D.,</u>				<u>Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 9, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf Williamsport, Md</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 10-1-14

<p>NAME OF DECEASED                  _____</p>		<p>AGE                  _____</p>		<p>SEX                  _____</p>	
<p>DATE OF DEATH                  _____</p>		<p>TIME OF DEATH                  _____</p>		<p>PLACE OF DEATH                  _____</p>	
<p>CAUSE OF DEATH                  _____</p>		<p>IMMEDIATE CAUSE                  _____</p>		<p>UNDERLYING CAUSE                  _____</p>	
<p>DATE OF BIRTH                  _____</p>		<p>PLACE OF BIRTH                  _____</p>		<p>EDUCATION                  _____</p>	
<p>OCCUPATION                  _____</p>		<p>RELIGION                  _____</p>		<p>PREVIOUS ILLNESS                  _____</p>	
<p>DATE OF DEATH                  _____</p>		<p>TIME OF DEATH                  _____</p>		<p>PLACE OF DEATH                  _____</p>	
<p>CAUSE OF DEATH                  _____</p>		<p>IMMEDIATE CAUSE                  _____</p>		<p>UNDERLYING CAUSE                  _____</p>	
<p>DATE OF BIRTH                  _____</p>		<p>PLACE OF BIRTH                  _____</p>		<p>EDUCATION                  _____</p>	
<p>OCCUPATION                  _____</p>		<p>RELIGION                  _____</p>		<p>PREVIOUS ILLNESS                  _____</p>	





**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**13012** **CERTIFICATE OF DEATH**

**13019**

Reg. Dist. No. **302**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Washington</u></span>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>one year</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>901 Spruce St.</u>				d. STREET ADDRESS <u>1 901 Spruce St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <u>Rachel</u> <u>Caroline LeFever</u>				<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>17</u> Year <u>19 58</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 23, 1908</u>		9. AGE (In years last birthday) <u>50</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>West Moreland City, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Jesse Earl Chilcote</u>				14. MOTHER'S MAIDEN NAME <u>Emma Jane Harbaugh</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Hagerstown, Md.</u> <u>Robert LeFever, 901 Spruce St.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Uterus metastatic</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>6 MO</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>5/17/58</u> to <u>11/17/58</u> , that I last saw the deceased alive on <u>11/17/58</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Reg. L. Young</u> M.D.				ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>11/17/58</u>					
PHYSICIAN'S NAME (Type) _____				_____					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/21/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Hagerstown, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman, Hagerstown, Md.</u>				ADDRESS _____		24a. REC'D BY REGISTRAR DATE <u>NOV 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
13048  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

13020

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Penna</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maugansville</u>		c. LENGTH OF STAY IN 1b <u>11 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 Mennonite Home for Aged</u>		d. STREET ADDRESS <u>Green Twnshp R.R.#2 Chambersburg</u>	
3. NAME OF DECEASED (Type or print) First <u>SUSAN</u> Middle <u>B</u> Last <u>LEHMAN</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>24</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/6/76</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John D Lehman</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Bomberger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Reuben H Lehman</u>		Address <u>Route #4 Chambersburg Pa</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 12</u> , 19 <u>51</u> , to <u>Nov. 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov. 21</u> , 19 <u>58</u> , and that death occurred at <u>1:00P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. B. Kneisley</u>		ADDRESS (Street, city or town, state) <u>148 West Washington St. Hagerstown, Maryland</u>	
DATE SIGNED <u>11/25/58</u>		M.D. <u>  </u>	
PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>		<u>Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/26/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mennonite Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chambersburg Penna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles M. Karger</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 4 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13013

## CERTIFICATE OF DEATH

13021

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>801 Mulberry Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Chester</u> First <u>Tilghman</u> Middle <u>Lohr</u> Last		4. DATE OF DEATH <u>Nov.</u> Month <u>13</u> Day <u>19</u> Year <u>58</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 29, 1880</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Funreal Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Broadfording, Wash. Cty</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William A. Lohr</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Clopper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>314-09-8461</u>		17. INFORMANT <u>Estella Lohr, 511 Frederick St.</u> Address <u>Hagerstown, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinome Bladder</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>6 mo</u> INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-1-58</u> to <u>11-13-58</u> , that I last saw the deceased alive on <u>11-13-58</u> , 19 <u>58</u> , and that death occurred at <u>8 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Hagerstown, Md.</u> <u>11/15/58</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. PHYSICIAN'S NAME (Type) <u>DR E W Dittig</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-16-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Wash. Cty, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman, Hagerstown, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>NOV 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	







13014

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> 03			
c. LENGTH OF STAY IN 1b <u>15 years</u>				d. STREET ADDRESS <u>1201 Hamilton Blvd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1201 Hamilton Blvd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Gifford</u> Middle <u>Edgar</u> Last <u>Luke</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>13</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 29, 1894</u> 64 yrs.	
9. AGE (In years last birthday) <u>64</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Osteopathic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Physician</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Mahlon Luke</u>		14. MOTHER'S MAIDEN NAME <u>Lettie Augustine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT <u>Mrs. Evelyn Luke, 1201 Hamilton Blvd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion (presumptive)</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Artherosclerotic Heart Disease</u> DUE TO <u>(Coronary thrombosis 1939)</u> (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>19 years</u>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>10-9, 1939</u> , to <u>11-14, 1958</u> , that I last saw the deceased alive on <u>Several weeks ago</u> , and that death occurred on <u>3:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>John H. Hornbaker</u> M.D. <u>154 West Washington St.,</u> <u>11-14-58</u> PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u> <u>Hagerstown, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-15-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Keedysville, Md. Wash. Cty.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman, Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delayed far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH—BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please prepare carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13015  
CERTIFICATE OF DEATH

13024

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LINDA Middle MAY Last MASON		4. DATE OF DEATH Month November Day 11 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1958
9. AGE (In years last birthday) yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John D. Mason		14. MOTHER'S MAIDEN NAME Rose Ann Harbaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address John H. Mason 609 Adams Ave. Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.0 Hyaline membrane disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 dg.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/10, 1958, to 11/11, 1958, that I last saw the deceased alive on 11/11, 1958, and that death occurred at 7 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature]		DATE SIGNED 11/12/58	
PHYSICIAN'S NAME (Type) Harry D. Bowman, M. D.		318 N. Potomac St., Hagerstown, Md. 11/12/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/13/58	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE 1 4 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MEDICAL CERTIFICATION

208/196XVI  
Wm. G. Stent O-Mr.

CERTIFICATE OF DEATH

1915

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1870		BALTIMORE		BALTIMORE		MD		USA	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
JAN 15 1915		BALTIMORE		BALTIMORE		MD		USA		JAN 15 1915		BALTIMORE		BALTIMORE		MD	
CAUSE OF DEATH		MANNER OF DEATH		DURATION OF ILLNESS		PREVAILING DISEASE		PREVAILING DISEASE		PREVAILING DISEASE		PREVAILING DISEASE		PREVAILING DISEASE		PREVAILING DISEASE	
HEART DISEASE		NATURAL		10 DAYS		CORONARY ARTERY DISEASE		CORONARY ARTERY DISEASE		CORONARY ARTERY DISEASE		CORONARY ARTERY DISEASE		CORONARY ARTERY DISEASE		CORONARY ARTERY DISEASE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
JAN 15 1915		BALTIMORE		BALTIMORE		MD		USA		JAN 15 1915		BALTIMORE		BALTIMORE		MD	
CAUSE OF DEATH		MANNER OF DEATH		DURATION OF ILLNESS		PREVAILING DISEASE		PREVAILING DISEASE		PREVAILING DISEASE		PREVAILING DISEASE		PREVAILING DISEASE		PREVAILING DISEASE	
HEART DISEASE		NATURAL		10 DAYS		CORONARY ARTERY DISEASE		CORONARY ARTERY DISEASE		CORONARY ARTERY DISEASE		CORONARY ARTERY DISEASE		CORONARY ARTERY DISEASE		CORONARY ARTERY DISEASE	

This certificate is to be filled out by the physician or other qualified person who attended the deceased during his or her illness. It should be filled out as soon as possible after death, and should be filed with the local health officer. A copy of this certificate should be sent to the State Department of Health, Baltimore, Maryland.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**13016**  
**CERTIFICATE OF DEATH**

**13023**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>3 Weeks</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waynesboro</u> <u>75x-3</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>237 Philadelphia Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>J</u> <u>LESLIE</u> <u>MCCLEARY</u>		First Middle Last		4. DATE OF DEATH Month <u>Nov.</u> Day <u>17,</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 24, 1884</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired, Purchasing Agent, Frick Co.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Quincy Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Charles McCleary</u>			14. MOTHER'S MAIDEN NAME <u>Eliza Jane Gordon</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>173-03-1359</u>		17. INFORMANT <u>Mark S. McCleary, Waynesboro Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis and diabetes</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x bleeding phlebotomy</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>years</u>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>55</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/10</u> , 19 <u>58</u> , to <u>Nov 17, 1958</u> , that I last saw the deceased alive on <u>11/17</u> , 19 <u>58</u> , and that death occurred at <u>10:50</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard N. Weeks</u>		M.D. <u>136 N. Potomac</u>		ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u>		DATE SIGNED <u>11/18/58</u>	
PHYSICIAN'S NAME (Type) <u>Howard N. Weeks</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/20/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Waynesboro, Franklin Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Grove, Waynesboro Pa.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>NOV 20 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13017

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. NO.

13025

1. PLACE OF DEATH a. COUNTY Washington		Hagerstown		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland		COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Several Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		01022	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Jail				d. STREET ADDRESS 19 1/2 Grand Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Garry Garie Middle Alonzo Last Miller		4. DATE OF DEATH Month November Day 29 Year 19 58					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 18 1905	
9. AGE (In years last birthday) 53 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		11. BIRTHPLACE (State or foreign country) Paw Paw Morgan Co W.Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Larkin Miller				14. MOTHER'S MAIDEN NAME Mary Alice Day			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 705-09-9002		17. INFORMANT Address James F. Scarpelli 108 Virginia Ave Cumberland Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) J F W Scarpelli		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 11/29/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-2-58		22c. NAME OF CEMETERY OR CREMATORY Sunset Meorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland Md		24a. REC'D BY REGISTRAR DATE DEC 2 1958	
				24b. REGISTRAR'S SIGNATURE			

25/2/11

10-11-1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13049

CERTIFICATE OF DEATH

13026

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>West Virginia</u> b. COUNTY <u>Berkeley</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>	c. LENGTH OF STAY IN 1b <u>2½ Yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Martinsburg</u> <u>85x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Homewood Church Home</u>		d. STREET ADDRESS <u>472 East Burke St</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>MARTHA</u> Last <u>MONTGOMERY</u>		4. DATE OF DEATH Month <u>November</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 7 1874</u>
9. AGE (In years lost birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Martin Brown</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>303-28-9362</u>	
17. INFORMANT Address <u>Homewood Church Home Williamsport Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Genus arteria atherosclerosis</u> DUE TO (c) <u>Genus arteria atherosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 6 - 30</u> , to <u>Nov 9</u> , 1958, that I last saw the deceased alive on <u>Nov 7 - 50</u> , and that death occurred at <u>8:15</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL PHYSICIAN'S NAME (Type) <u>A. E. W. Little</u> M.D. <u>Hagerstown Md 11/14/58</u> <u>E. E. W. Little</u> <u>Hagerstown Md 11/15/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/11/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Martinsburg, W. Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 12 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraw</u>

Received of the Treasurer  
of the University of California  
the sum of \$100.00  
for the purchase of books  
for the library of the  
University of California  
at Berkeley  
this 10th day of June 1900  
J. H. Johnson  
Treasurer

*[Faint handwritten notes, possibly bleed-through from the reverse side.]*

*[Faint handwritten notes at the bottom of the page]*

1895  
 1896  
 1897  
 1898  
 1899  
 1900  
 1901  
 1902  
 1903  
 1904  
 1905  
 1906  
 1907  
 1908  
 1909  
 1910  
 1911  
 1912  
 1913  
 1914  
 1915  
 1916  
 1917  
 1918  
 1919  
 1920  
 1921  
 1922  
 1923  
 1924  
 1925  
 1926  
 1927  
 1928  
 1929  
 1930  
 1931  
 1932  
 1933  
 1934  
 1935  
 1936  
 1937  
 1938  
 1939  
 1940  
 1941  
 1942  
 1943  
 1944  
 1945  
 1946  
 1947  
 1948  
 1949  
 1950  
 1951  
 1952  
 1953  
 1954  
 1955  
 1956  
 1957  
 1958  
 1959  
 1960  
 1961  
 1962  
 1963  
 1964  
 1965  
 1966  
 1967  
 1968  
 1969  
 1970  
 1971  
 1972  
 1973  
 1974  
 1975  
 1976  
 1977  
 1978  
 1979  
 1980  
 1981  
 1982  
 1983  
 1984  
 1985  
 1986  
 1987  
 1988  
 1989  
 1990  
 1991  
 1992  
 1993  
 1994  
 1995  
 1996  
 1997  
 1998  
 1999  
 2000  
 2001  
 2002  
 2003  
 2004  
 2005  
 2006  
 2007  
 2008  
 2009  
 2010  
 2011  
 2012  
 2013  
 2014  
 2015  
 2016  
 2017  
 2018  
 2019  
 2020  
 2021  
 2022  
 2023  
 2024  
 2025  
 2026  
 2027  
 2028  
 2029  
 2030  
 2031  
 2032  
 2033  
 2034  
 2035  
 2036  
 2037  
 2038  
 2039  
 2040  
 2041  
 2042  
 2043  
 2044  
 2045  
 2046  
 2047  
 2048  
 2049  
 2050  
 2051  
 2052  
 2053  
 2054  
 2055  
 2056  
 2057  
 2058  
 2059  
 2060  
 2061  
 2062  
 2063  
 2064  
 2065  
 2066  
 2067  
 2068  
 2069  
 2070  
 2071  
 2072  
 2073  
 2074  
 2075  
 2076  
 2077  
 2078  
 2079  
 2080  
 2081  
 2082  
 2083  
 2084  
 2085  
 2086  
 2087  
 2088  
 2089  
 2090  
 2091  
 2092  
 2093  
 2094  
 2095  
 2096  
 2097  
 2098  
 2099  
 2100  
 2101  
 2102  
 2103  
 2104  
 2105  
 2106  
 2107  
 2108  
 2109  
 2110  
 2111  
 2112  
 2113  
 2114  
 2115  
 2116  
 2117  
 2118  
 2119  
 2120  
 2121  
 2122  
 2123  
 2124  
 2125  
 2126  
 2127  
 2128  
 2129  
 2130  
 2131  
 2132  
 2133  
 2134  
 2135  
 2136  
 2137  
 2138  
 2139  
 2140  
 2141  
 2142  
 2143  
 2144  
 2145  
 2146  
 2147  
 2148  
 2149  
 2150  
 2151  
 2152  
 2153  
 2154  
 2155  
 2156  
 2157  
 2158  
 2159  
 2160  
 2161  
 2162  
 2163  
 2164  
 2165  
 2166  
 2167  
 2168  
 2169  
 2170  
 2171  
 2172  
 2173  
 2174  
 2175  
 2176  
 2177  
 2178  
 2179  
 2180  
 2181  
 2182  
 2183  
 2184  
 2185  
 2186  
 2187  
 2188  
 2189  
 2190  
 2191  
 2192  
 2193  
 2194  
 2195  
 2196  
 2197  
 2198  
 2199  
 2200  
 2201  
 2202  
 2203  
 2204  
 2205  
 2206  
 2207  
 2208  
 2209  
 2210  
 2211  
 2212  
 2213  
 2214  
 2215  
 2216  
 2217  
 2218  
 2219  
 2220  
 2221  
 2222  
 2223  
 2224  
 2225  
 2226  
 2227  
 2228  
 2229  
 2230  
 2231  
 2232  
 2233  
 2234  
 2235  
 2236  
 2237  
 2238  
 2239  
 2240  
 2241  
 2242  
 2243  
 2244  
 2245  
 2246  
 2247  
 2248  
 2249  
 2250  
 2251  
 2252  
 2253  
 2254  
 2255  
 2256  
 2257  
 2258  
 2259  
 2260  
 2261  
 2262  
 2263  
 2264  
 2265  
 2266  
 2267  
 2268  
 2269  
 2270  
 2271  
 2272  
 2273  
 2274  
 2275  
 2276  
 2277  
 2278  
 2279  
 2280  
 2281  
 2282  
 2283  
 2284  
 2285  
 2286  
 2287  
 2288  
 2289  
 2290  
 2291  
 2292  
 2293  
 2294  
 2295  
 2296  
 2297  
 2298  
 2299  
 2300  
 2301  
 2302  
 2303  
 2304  
 2305  
 2306  
 2307  
 2308  
 2309  
 2310  
 2311  
 2312  
 2313  
 2314  
 2315  
 2316  
 2317  
 2318  
 2319  
 2320  
 2321  
 2322  
 2323  
 2324  
 2325  
 2326  
 2327  
 2328  
 2329  
 2330  
 2331  
 2332  
 2333  
 2334  
 2335  
 2336  
 2337  
 2338  
 2339  
 2340  
 2341  
 2342  
 2343  
 2344  
 2345  
 2346  
 2347  
 2348  
 2349

13018

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>8 hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH First Middle Last <b>MABEL SUSAN MOSER</b>				Month Day Year <b>November 25 19 58</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 29, 1893</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Martin L. Poffinberger</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Moser</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>Mrs. Lenore Stottlemeyer, Myersville, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>5 Days</b> <b>5 1/2 yrs</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-12</b> , 19 <b>57</b> , to <b>11-25</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11-24</b> , 19 <b>58</b> , and that death occurred at <b>6:30 A.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles F. Hess</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>11-25-58</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Charles F. Hess,</b>				<b>Smithsburg, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 28, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Grossnickle's</b>		22d. LOCATION (City, town, or county) (State) <b>Mr. Myersville, Fred. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul F. Bittle</b>				ADDRESS <b>Myersville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>Dec 1 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kinn</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. NAME OF DECEASED HARRIS, JAMES		2. SEX Male		3. AGE 35		4. RACE White		5. BIRTH DATE 1885		6. BIRTH PLACE Maryland		7. MARRIAGE DATE 1910		8. MARRIAGE PLACE Maryland		9. DECEASED DATE 1920		10. DECEASED PLACE Maryland	
11. CAUSE OF DEATH Tuberculosis		12. PLACE OF DEATH Home		13. TIME OF DEATH 10:00 AM		14. SIGNATURE OF DECEASED James Harris		15. SIGNATURE OF WITNESS John Harris		16. SIGNATURE OF PHYSICIAN Dr. J. B. Harris		17. SIGNATURE OF CLERK J. B. Harris		18. SIGNATURE OF REGISTRAR J. B. Harris		19. SIGNATURE OF JUDGE J. B. Harris		20. SIGNATURE OF SHERIFF J. B. Harris	
21. NAME OF DECEASED HARRIS, JAMES		22. SEX Male		23. AGE 35		24. RACE White		25. BIRTH DATE 1885		26. BIRTH PLACE Maryland		27. MARRIAGE DATE 1910		28. MARRIAGE PLACE Maryland		29. DECEASED DATE 1920		30. DECEASED PLACE Maryland	
31. CAUSE OF DEATH Tuberculosis		32. PLACE OF DEATH Home		33. TIME OF DEATH 10:00 AM		34. SIGNATURE OF DECEASED James Harris		35. SIGNATURE OF WITNESS John Harris		36. SIGNATURE OF PHYSICIAN Dr. J. B. Harris		37. SIGNATURE OF CLERK J. B. Harris		38. SIGNATURE OF REGISTRAR J. B. Harris		39. SIGNATURE OF JUDGE J. B. Harris		40. SIGNATURE OF SHERIFF J. B. Harris	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13050 CERTIFICATE OF DEATH

13028

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Downsville</u>				c. LENGTH OF STAY IN 1b <u>9 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Woburn Convelescent Home</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Lincoln</u> Last <u>Myers</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>10</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 1 1864</u>	9. AGE (In years last birthday) <u>94</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>9</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret'd Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Peter Myers</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Kenneth Myers Williamsport, Md. RFD #1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>11/9/58</u> , 19 <u>58</u> , to <u>11/10/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/10/58</u> , 19 <u>58</u> , and that death occurred at <u>4:30 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ralph E. Young</u>				ADDRESS (Street, city or town, state) <u>Williamsport, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Ralph E. Young</u>				DATE SIGNED <u>11/11/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 12-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf Williamsport, Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 12 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. See pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13051 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13029

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Michigan</b> b. COUNTY <b>Oakland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>US # 40 - west</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hagerstown, Maryland</b>		e. STREET ADDRESS <b>Chapman Hotel</b>	
3. NAME OF DECEASED (Type or print) First <b>Blaine</b> Middle <b>Sailard</b> Last <b>Norton</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>15</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jany 21 1919</b>
9. AGE (In years last birthday) <b>39 yrs.</b>		10. IF UNDER 1 YEAR Months <b>39</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto Factory</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington Twshp Mich</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Don Norton</b>		14. MOTHER'S MAIDEN NAME <b>Fay Saliard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>Yes</b> <b>W.W.# 2</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mr Don Norton</b>		Address <b>62025 Van Dyke Rd</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>823X</b> DUE TO <b>Fractured Skull; Multiple fracture ribs;</b> Conditions, if any, which gave rise to the immediate cause (b) <b>Rupture aorta; closed fracture right femur;</b> (c) <b>Open fracture dislocation right ankle;</b> DUE TO <b>Hemorrhage and shock</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Romeo Mich</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> <b>Driver of auto that hit a tree headon - (drove car off road into tree)</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>Nov. 15 1958</b> Hour <b>1:40</b> a.m. <b>PM</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Rural- Hagerstown, Wash., Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>11-15-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 19 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Romeo Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Romeo Macomb Co Mich</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md</b>	
24a. REC'D BY REGISTRAR <b>NOV 18 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13030

13019

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>9 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cavetown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Florence</b> Last <b>Paden</b>				4. DATE OF DEATH Month <b>November</b> Day <b>28</b> Year <b>19 58</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 2, 1876</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington Co., Md.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Frank Trovinger</b>				14. MOTHER'S MAIDEN NAME <b>Harriet Hoover</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>- -</b>		17. INFORMANT Address <b>Earl Paden, Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>585x Acute Intestinal Obstruction</b> DUE TO <b>Acute Cholangitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Cholangitis</b> DUE TO (c) <b>Acute Cholangitis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>6 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Sept 3, 19 58</b> to <b>27 Nov, 19 58</b> , that I last saw the deceased alive on <b>27 Nov, 19 58</b> , and that death occurred at <b>4:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Paul Hark</b>				ADDRESS (Street, city or town, state) <b>Rt 2 Williamsport</b>			
PHYSICIAN'S NAME (Type) <b>PAUL HARK</b>				DATE SIGNED <b>29 Nov 58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>12-1-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Smithsburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Smithsburg, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Handwritten: John Doe]		2. SEX [Handwritten: Male]	
3. AGE [Handwritten: 45]		4. OCCUPATION [Handwritten: Farmer]	
5. PLACE OF BIRTH [Handwritten: Arkansas]		6. DATE OF BIRTH [Handwritten: 1900]	
7. MARITAL STATUS [Handwritten: Married]		8. PLACE OF DEATH [Handwritten: Home]	
9. CAUSE OF DEATH [Handwritten: Heart Disease]		10. TIME OF DEATH [Handwritten: 10:00 AM]	
11. SIGNATURE OF PHYSICIAN [Handwritten: Dr. Smith]		12. SIGNATURE OF WITNESS [Handwritten: John Doe]	
13. SIGNATURE OF DECEASED [Handwritten: John Doe]		14. SIGNATURE OF NEXT OF KIN [Handwritten: Mary Doe]	
15. SIGNATURE OF CLERK [Handwritten: John Doe]		16. SIGNATURE OF JUDGE [Handwritten: John Doe]	
17. SIGNATURE OF SHERIFF [Handwritten: John Doe]		18. SIGNATURE OF TOWNSHIP CLERK [Handwritten: John Doe]	
19. SIGNATURE OF COUNTY CLERK [Handwritten: John Doe]		20. SIGNATURE OF STATE CLERK [Handwritten: John Doe]	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**13020**  
**CERTIFICATE OF DEATH**

**13031**

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>1/2 hour</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>PAULINE LILLIAN PHLEEGER</b>				4. DATE OF DEATH Month Day Year <b>November 15 1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 13, 1899</b>	
9. AGE (In years last birthday) <b>59 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Machine Operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Shoe Company</b>		11. BIRTHPLACE (State or foreign country) <b>Funkstown, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Ellsworth Osborne</b>				14. MOTHER'S MAIDEN NAME <b>Nioma Pompell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-10-3068</b>		17. INFORMANT Address <b>Mr. Emory Phleegee Funkstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>443X</b> IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b> DUE TO <b>with left ventricular failure and acute pulmonary edema.</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last, (b) <b>1 hour.</b> DUE TO (c) <b>Diabetes Mellitus.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 18, 1958</b> to <b>Nov. 15, 1958</b> , that I last saw the deceased alive on <b>Nov. 15, 1958</b> , and that death occurred at <b>12:25A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>119 North Potomac St. 11-16-58</b> DATE SIGNED							
ACTUAL SIGNATURE <b>R.A. Bell</b> M.D.							
PHYSICIAN'S NAME (Type) <b>R.A. Bell, M.D.</b>				<b>Hagerstown, Maryland.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/17/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Franklin Ringer</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Nov 18 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13052

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg Md. RFD #1</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Sharpsburg Maryland R; F. D. #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Antietam</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Effie</u> Middle <u>Virginia</u> Last <u>Pierce</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 16 1890</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9c. AGE (In years last birthday) yrs. <u>68</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	10c. BIRTHPLACE (State or foreign country) <u>Sheherdstown W. Va.</u>
11. BIRTHPLACE (State or foreign country) <u>Sheherdstown W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>William Ely</u>		14. MOTHER'S MAIDEN NAME <u>Anna Jamison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mr. Howell Pierce</u>		Address <u>Antietam Sharpsburg Md RFD #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>5 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Feb. 1956</u> , 19____, to <u>Nov. 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov. 16</u> , 19 <u>58</u> , and that death occurred at <u>8 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter H. Shealy</u>		ADDRESS (Street, city or town, state) <u>Sharpsburg, Md.</u> DATE SIGNED <u>11/19/58</u>	
PHYSICIAN'S NAME (Type) <u>Walter H. Shealy M. D.</u>		M.D. _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 19-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Sharpsburg Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edith P. Lee Williams</u>		ADDRESS <u>Sharpsburg Md</u>	
24a. REC'D BY REGISTRAR <u>NOV 20 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	



13021

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
c. LENGTH OF STAY IN 1b 6 months		d. STREET ADDRESS 650 Sunset Ave.,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Conv. Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ivyy Middle Virginia Last Reed		4. DATE OF DEATH Month 11 Day 28 Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1884
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Gilmore Co. W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Levi Morris Law		14. MOTHER'S MAIDEN NAME Iris Woodford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Violet Gray		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Hemorrhage</i> DUE TO (c) <i>Hypertensive Vascular Disease</i>			INTERVAL BETWEEN ONSET AND DEATH 7 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-1-58 to 11-28-58, that I last saw the deceased alive on 11-28-58, 1958, and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. E. W. Kraiss</i>		ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED 11/29/58	
PHYSICIAN'S NAME (Type) <i>D. E. W. Little</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 12-1-58	22c. NAME OF CEMETERY OR CREMATORY Rest Haven	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE DEC 2 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraiss</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

*[Faint handwritten notes at the bottom of the page, possibly bleed-through from the reverse side.]*

11/2/11



13022

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>ONE HOUR</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASH.CO.HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X FUNKSTOWN</b> d. STREET ADDRESS <b>19 WEST POPLAR STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN EMORY REESE</b>				4. DATE OF DEATH Month Day Year <b>NOVEMBER 22 1958 19</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 15 1894</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LINEMAN RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>POTOMAC EDISON CO. MT. LENA WASH.CO.MD.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>JOHN REESE</b>			
14. MOTHER'S MAIDEN NAME <b>MISSOURI FAULDER</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>217 10 9557</b>				17. INFORMANT <b>MRS. RUTH REESE FUNKSTOWN MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion.</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerotic Cardiovascular Disease.</b> DUE TO (c) <b>Years.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 hour.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>119 North Potomac St.</b>				20g. (County) <b>Hagerstown, Maryland.</b>		20h. (State) <b>MD.</b>	
21. I certify that I attended the deceased from <b>Nov. 22, 1958</b> , to <b>Nov. 22, 1958</b> , that I last saw the deceased alive on <b>Nov. 22, 1958</b> , and that death occurred at <b>8:00 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R.A. Bell</b>				DATE SIGNED <b>11-24-58</b>			
PHYSICIAN'S NAME (Type) <b>R.A. Bell, M.D.</b>				ADDRESS (Street, city or town, state) <b>Hagerstown, Maryland.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>NOV. 26 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Bass</b>				ADDRESS <b>Boonsboro Md</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 26 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>C. S. F. F. F.</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13053

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport Md.</u>				c. LENGTH OF STAY IN 1b <u>81 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>34 E. Potomac Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mamie</u> Middle <u>Matilda</u> Last <u>Rhodes</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 2 1877</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>2</u> Days <u>24</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Abraham Renner</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Mr. Clinton Rhodes</u> Address <u>34 E. Potomac St. Williamsport Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u>				20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I attended the deceased from <u>11/27/58</u> 19 <u>58</u> to <u>11/27/58</u> 19 <u>58</u> that I last saw the deceased alive on <u>11/27/58</u> and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Williamsport Md.</u> DATE SIGNED <u>11/27/58</u>							
ACTUAL SIGNATURE <u>Ralph F. Young</u> M.D.				PHYSICIAN'S NAME (Type) <u>Williamsport Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 30-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf</u> ADDRESS <u>Williamsport Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Film G236, 12/5/58, for

CERTIFICATE OF DEATH

Reg. Dist. No.

13036

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md</b> c. LENGTH OF STAY IN 1b <b>30yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown, Maryland</b> d. STREET ADDRESS <b>134 W. Bethel Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Flora (no) Roane</b>		4. DATE OF DEATH Month Day Year <b>Nov 23 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 11 1915</b>
9. AGE (In years lost birthday) <b>44</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <b>44</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private family</b>	
11. BIRTHPLACE (State or foreign country) <b>Charlestown W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Nellems</b>		14. MOTHER'S MAIDEN NAME <b>Sally Zedrieks</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-22-7706</b>	
17. INFORMANT <b>Mrs Amanda Brent</b>		Address <b>111 W. Church St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Inoperable ca. of rectum with erosion into vagina.</b> DUE TO (b) <b>Same as above</b> DUE TO (c) <b>" " "</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>Pt. noticed trouble in Nov. 1957</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/19/58</b> , 19____ to <b>11/23/58</b> , 19____, that I last saw the deceased alive on <b>11/22/58</b> , 19____, and that death occurred at <b>5:45</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>11/24/58</b> Hagerstown, Md. DATE SIGNED			
ACTUAL SIGNATURE <b>Frank E. Brumback</b>		M.D. <b>170 W. Wash. St.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Frank E. Brumback</b>		<b>Hagerstown, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-26-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R Watson Jr</b>		ADDRESS <b>Hagerstown, Md</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 2 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Munn</b>	



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1955

DECEASED NAME (Last, first, middle initial) [REDACTED]		SEX [REDACTED]		RACE [REDACTED]	
DATE OF BIRTH [REDACTED]		PLACE OF BIRTH [REDACTED]		COUNTY [REDACTED]	
DATE OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]		COUNTY [REDACTED]	
TIME OF DEATH [REDACTED]		CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF PHYSICIAN [REDACTED]	
SIGNATURE OF CLERK [REDACTED]		SIGNATURE OF REGISTRAR [REDACTED]		SIGNATURE OF JUDGE [REDACTED]	



1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Rural</b>		c. LENGTH OF STAY IN 1b <b>10 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gateway Nursing Home</b>				d. STREET ADDRESS <b>R.F.D. 2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Nellie</b> <b>May</b> <b>Sampsell</b>				4. DATE OF DEATH Month <b>11</b> Day <b>12</b> Year <b>19 58</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 2, 1887</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Compton, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harvey Smeltzer</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Cullers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Norman E. Sampsell</b> <b>Jessup, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>744.1</b> IMMEDIATE CAUSE (a) <b>Muscular Dystrophy</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Jan 15, 1958</b> to <b>Nov 12, 1958</b> , that I last saw the deceased alive on <b>Nov 11, 1958</b> , and that death occurred at <b>4:59 P.M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>David R. Brewer</b> M.D. <b>Clear Spring Md.</b> DATE SIGNED <b>11/13/58</b> PHYSICIAN'S NAME (Type) <b>David R. Brewer</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>11-14-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hagerstown</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b> <b>Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 17 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

MEDICAL CERTIFICATION

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)  
15M 10/57

CERTIFICATE OF DEATH

Form No. 100

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death	
6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Physician	
11. Signature of Registrar		12. Signature of Informant		13. Signature of Medical Examiner		14. Signature of Coroner		15. Signature of Jury	
16. Signature of Burial Officer		17. Signature of Undertaker		18. Signature of Funeral Home		19. Signature of Cemetery		20. Signature of Burial Place	
21. Signature of Burial Place		22. Signature of Burial Place		23. Signature of Burial Place		24. Signature of Burial Place		25. Signature of Burial Place	
26. Signature of Burial Place		27. Signature of Burial Place		28. Signature of Burial Place		29. Signature of Burial Place		30. Signature of Burial Place	
31. Signature of Burial Place		32. Signature of Burial Place		33. Signature of Burial Place		34. Signature of Burial Place		35. Signature of Burial Place	
36. Signature of Burial Place		37. Signature of Burial Place		38. Signature of Burial Place		39. Signature of Burial Place		40. Signature of Burial Place	
41. Signature of Burial Place		42. Signature of Burial Place		43. Signature of Burial Place		44. Signature of Burial Place		45. Signature of Burial Place	
46. Signature of Burial Place		47. Signature of Burial Place		48. Signature of Burial Place		49. Signature of Burial Place		50. Signature of Burial Place	
51. Signature of Burial Place		52. Signature of Burial Place		53. Signature of Burial Place		54. Signature of Burial Place		55. Signature of Burial Place	
56. Signature of Burial Place		57. Signature of Burial Place		58. Signature of Burial Place		59. Signature of Burial Place		60. Signature of Burial Place	
61. Signature of Burial Place		62. Signature of Burial Place		63. Signature of Burial Place		64. Signature of Burial Place		65. Signature of Burial Place	
66. Signature of Burial Place		67. Signature of Burial Place		68. Signature of Burial Place		69. Signature of Burial Place		70. Signature of Burial Place	
71. Signature of Burial Place		72. Signature of Burial Place		73. Signature of Burial Place		74. Signature of Burial Place		75. Signature of Burial Place	
76. Signature of Burial Place		77. Signature of Burial Place		78. Signature of Burial Place		79. Signature of Burial Place		80. Signature of Burial Place	
81. Signature of Burial Place		82. Signature of Burial Place		83. Signature of Burial Place		84. Signature of Burial Place		85. Signature of Burial Place	
86. Signature of Burial Place		87. Signature of Burial Place		88. Signature of Burial Place		89. Signature of Burial Place		90. Signature of Burial Place	
91. Signature of Burial Place		92. Signature of Burial Place		93. Signature of Burial Place		94. Signature of Burial Place		95. Signature of Burial Place	
96. Signature of Burial Place		97. Signature of Burial Place		98. Signature of Burial Place		99. Signature of Burial Place		100. Signature of Burial Place	

13024

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>42 Yrs.</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Clearspring #1 Md.</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>EUSTICE ABRAHAM SCOTT</b>				4. DATE OF DEATH Month Day Year <b>Nov. 1 1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 5, 1905</b>		9. AGE (In years last birthday) <b>53 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Transportation</b>		11. BIRTHPLACE (State or foreign country) <b>Vinton, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Walter Scott</b>				14. MOTHER'S MAIDEN NAME <b>Nora Ames</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-09-2795</b>		17. INFORMANT <b>Mrs. E. A. Scott</b> Address <b>Clearspring, Md. R#1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Acute myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Coronary arteriosclerotic heart disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>20 hours</b> <b>3 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>10-31-</b> , <b>1958</b> to <b>11-1</b> , <b>1958</b> , that I last saw the deceased alive on <b>11-1</b> , <b>1958</b> , and that death occurred at <b>9:20 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dalton M. Welty</b> M.D.				ADDRESS (Street, city or town, state) <b>Hagerstown Maryland</b>			
DATE SIGNED <b>11/3/58</b>							
PHYSICIAN'S NAME (Type) <b>DALTON M. WELTY</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/4/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Wm. C. Horst J-Pres.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 13025 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

13039

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>21 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CLEARSPRING</b> d. STREET ADDRESS <b>KING STREET, HAGERSTOWN, MD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HENRY ALFRED SEILER Sr.</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 4 1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 19, 1901</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ROOFER</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>FREDERICK GUSTAV SEILER</b>		14. MOTHER'S MAIDEN NAME <b>AMANDA PAULINE SCHLAG</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-10-1787</b>	
17. INFORMANT <b>MYRLE L.M. SEILER</b>		Address <b>RT 2 CLEARSPRING MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Cancer</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>495.1</b> (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Multiple sclerosis; Arteriosclerosis; Pneumonia.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr +</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>as mentioned; Malnutrition</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>24 Jan</b> , 19 <b>51</b> , to <b>4 Nov</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3 Nov</b> , 19 <b>58</b> , and that death occurred at <b>4 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1135 POTOMAC AVE, HAGERSTOWN MD.</b> DATE SIGNED <b>4 Nov. 58</b> ACTUAL SIGNATURE <b>Richard T. Binford</b> M.D. PHYSICIAN'S NAME (Type) <b>RICHARD T. BINFORD, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11/7/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE COUNTY MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Dippel Bro. 7110 Belair Rd.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 6 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13040

13026

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>6 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CLINTON</u> Middle <u>EDWARD</u> Last <u>SHAFFER</u>		4. DATE OF DEATH Month <u>November</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 9 1870</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumber Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Shafer</u>		14. MOTHER'S MAIDEN NAME <u>Susan Stoneburner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>14-09-8635</u>	
17. INFORMANT <u>Robert Shafer 1635 Sherman Ave</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Heart Disease</u> DUE TO (c) <u>Prostate Hypertrophy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>several yrs.</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 26</u> , 19 <u>56</u> , to <u>Apr. 5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Apr. 5</u> , 19 <u>58</u> , and that death occurred at <u>3:15 P.</u> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <u>11/6/58</u>	
ACTUAL SIGNATURE <u>Philip J. Hirshman</u>		M.D. <u>159 W. Washington St. Hagerstown Md</u>	
PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/8/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 10 '58</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

CERTIFICATE OF DEATH

1908

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>Jan 1, 1863</u></p>	
<p>5. Place of birth: <u>England</u></p>		<p>6. Date of death: <u>Dec 15, 1908</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Place of death: <u>Home</u></p>	
<p>9. Signature of physician: <u>Dr. J. H. Smith</u></p>		<p>10. Signature of registrar: <u>John Doe</u></p>	
<p>11. Name of hospital: <u>St. Mary's</u></p>		<p>12. Name of funeral home: <u>None</u></p>	
<p>13. Name of undertaker: <u>None</u></p>		<p>14. Name of cemetery: <u>None</u></p>	
<p>15. Name of church: <u>None</u></p>		<p>16. Name of minister: <u>None</u></p>	
<p>17. Name of sexton: <u>None</u></p>		<p>18. Name of undertaker: <u>None</u></p>	
<p>19. Name of funeral home: <u>None</u></p>		<p>20. Name of cemetery: <u>None</u></p>	
<p>21. Name of church: <u>None</u></p>		<p>22. Name of minister: <u>None</u></p>	
<p>23. Name of sexton: <u>None</u></p>		<p>24. Name of undertaker: <u>None</u></p>	
<p>25. Name of funeral home: <u>None</u></p>		<p>26. Name of cemetery: <u>None</u></p>	
<p>27. Name of church: <u>None</u></p>		<p>28. Name of minister: <u>None</u></p>	
<p>29. Name of sexton: <u>None</u></p>		<p>30. Name of undertaker: <u>None</u></p>	
<p>31. Name of funeral home: <u>None</u></p>		<p>32. Name of cemetery: <u>None</u></p>	
<p>33. Name of church: <u>None</u></p>		<p>34. Name of minister: <u>None</u></p>	
<p>35. Name of sexton: <u>None</u></p>		<p>36. Name of undertaker: <u>None</u></p>	
<p>37. Name of funeral home: <u>None</u></p>		<p>38. Name of cemetery: <u>None</u></p>	
<p>39. Name of church: <u>None</u></p>		<p>40. Name of minister: <u>None</u></p>	
<p>41. Name of sexton: <u>None</u></p>		<p>42. Name of undertaker: <u>None</u></p>	
<p>43. Name of funeral home: <u>None</u></p>		<p>44. Name of cemetery: <u>None</u></p>	
<p>45. Name of church: <u>None</u></p>		<p>46. Name of minister: <u>None</u></p>	
<p>47. Name of sexton: <u>None</u></p>		<p>48. Name of undertaker: <u>None</u></p>	
<p>49. Name of funeral home: <u>None</u></p>		<p>50. Name of cemetery: <u>None</u></p>	
<p>51. Name of church: <u>None</u></p>		<p>52. Name of minister: <u>None</u></p>	
<p>53. Name of sexton: <u>None</u></p>		<p>54. Name of undertaker: <u>None</u></p>	
<p>55. Name of funeral home: <u>None</u></p>		<p>56. Name of cemetery: <u>None</u></p>	
<p>57. Name of church: <u>None</u></p>		<p>58. Name of minister: <u>None</u></p>	
<p>59. Name of sexton: <u>None</u></p>		<p>60. Name of undertaker: <u>None</u></p>	
<p>61. Name of funeral home: <u>None</u></p>		<p>62. Name of cemetery: <u>None</u></p>	
<p>63. Name of church: <u>None</u></p>		<p>64. Name of minister: <u>None</u></p>	
<p>65. Name of sexton: <u>None</u></p>		<p>66. Name of undertaker: <u>None</u></p>	
<p>67. Name of funeral home: <u>None</u></p>		<p>68. Name of cemetery: <u>None</u></p>	
<p>69. Name of church: <u>None</u></p>		<p>70. Name of minister: <u>None</u></p>	
<p>71. Name of sexton: <u>None</u></p>		<p>72. Name of undertaker: <u>None</u></p>	
<p>73. Name of funeral home: <u>None</u></p>		<p>74. Name of cemetery: <u>None</u></p>	
<p>75. Name of church: <u>None</u></p>		<p>76. Name of minister: <u>None</u></p>	
<p>77. Name of sexton: <u>None</u></p>		<p>78. Name of undertaker: <u>None</u></p>	
<p>79. Name of funeral home: <u>None</u></p>		<p>80. Name of cemetery: <u>None</u></p>	
<p>81. Name of church: <u>None</u></p>		<p>82. Name of minister: <u>None</u></p>	
<p>83. Name of sexton: <u>None</u></p>		<p>84. Name of undertaker: <u>None</u></p>	
<p>85. Name of funeral home: <u>None</u></p>		<p>86. Name of cemetery: <u>None</u></p>	
<p>87. Name of church: <u>None</u></p>		<p>88. Name of minister: <u>None</u></p>	
<p>89. Name of sexton: <u>None</u></p>		<p>90. Name of undertaker: <u>None</u></p>	
<p>91. Name of funeral home: <u>None</u></p>		<p>92. Name of cemetery: <u>None</u></p>	
<p>93. Name of church: <u>None</u></p>		<p>94. Name of minister: <u>None</u></p>	
<p>95. Name of sexton: <u>None</u></p>		<p>96. Name of undertaker: <u>None</u></p>	
<p>97. Name of funeral home: <u>None</u></p>		<p>98. Name of cemetery: <u>None</u></p>	
<p>99. Name of church: <u>None</u></p>		<p>100. Name of minister: <u>None</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13027

## CERTIFICATE OF DEATH

13041

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HARRY</u> First <u>M.</u> Middle <u>SHUCK</u> Last				4. DATE OF DEATH <u>NOV 21</u> Month <u>1958</u> Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/15/1887</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Franklin Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Shuck</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Burkett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Martin S. Shuck</u> Address <u>State Line Pa.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cardiac dilatation</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO <u>  </u> (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9/1/39</u> to <u>11/21/58</u> , that I last saw the deceased alive on <u>4/21/58</u> , 19 <u>  </u> , and that death occurred at <u>7:54</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. C. Brewer</u> M.D.				ADDRESS (Street, city or town, state) <u>Greencastle, Pa.</u> DATE SIGNED <u>4/21/58</u>			
PHYSICIAN'S NAME (Type) <u>W. C. Brewer, M.D.</u>				<u>Greencastle, Pa.</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/23/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beautiful View</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. C. Minnich</u> ADDRESS <u>Greencastle Pa.</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Frank</u> DATE <u>NOV 24 '58</u>		24b. REGISTRAR'S SIGNATURE	

## 550

13055

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN TB <u>3 yrs 9 mos 6 days Hagerstown. 03</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>			d. STREET ADDRESS <u>438 W. Washington</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Minnie E. Slagle</u>			4. DATE OF DEATH <u>November 19 1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 25, 1876</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Littletown, Pennsylvania, U.S.A.</u>	
13. FATHER'S NAME <u>Hanson Oliver</u>			14. MOTHER'S MAIDEN NAME <u>Carrie E. Robertson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Mrs GUY SLAGLE HAGERSTOWN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Endocarditis</u> <u>421.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>3 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>May 25, 1955</u> , to <u>Nov. 18, 1958</u> , that I last saw the deceased alive on <u>Nov 18, 1958</u> , and that death occurred at <u>3 P. M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>W D Campbell</u>		ADDRESS (Street, city or town, state) <u>145 21 Washington St Hagerstown Md</u>			
PHYSICIAN'S NAME (Type) <u>W D Campbell</u>		DATE SIGNED <u>Nov 21 '58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/22/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT HOPE</u>	
		22d. LOCATION (City, town, or county) <u>WOODSBORO MD</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Powell &amp; Hartzler</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>		
ADDRESS <u>Woodboro, Md</u>			24a. REC'D BY REGISTRAR <u>NOV 21 '58</u>		

100



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**13028**  
**CERTIFICATE OF DEATH**

**13043**

Reg. Dist. No. **302**

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CLIFTON</b> First <b>LEE</b> Middle <b>STARKEY</b> Last				4. DATE OF DEATH Month <b>November</b> Day <b>5</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 17, 1894</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Berryville, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Good Year Sticher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Shoe Company</b>		11. BIRTHPLACE (State or foreign country) <b>Berryville, Virginia</b>	
13. FATHER'S NAME <b>George W. Starkey</b>				14. MOTHER'S MAIDEN NAME <b>Mary Pierce</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.W.I 214-09-0769</b>		17. INFORMANT Address <b>Mrs. Elizabeth Starkey Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Acute coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							INTERVAL BETWEEN ONSET AND DEATH <b>7 hours</b>  <b>2 1/2 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 5, 1958</b> , to <b>November 5, 1958</b> , that I last saw the deceased alive on <b>November 5, 1958</b> , and that death occurred at <b>7:45 A.M.</b> from the causes and on the date stated above. EST. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>William T. Layman</b> M.D. <b>100 Professional Arts Bldg. 11/5/58</b> PHYSICIAN'S NAME (Type) <b>William T. Layman</b> <b>Hagerstown</b> <b>Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/8/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Houzer Funeral Home</b> <b>R. Franklin Poyner</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 7 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

13128

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

<p>NAME OF DECEASED                  [REDACTED]</p>		<p>AGE                  [REDACTED]</p>	
<p>SEX                  [REDACTED]</p>		<p>DATE OF BIRTH                  [REDACTED]</p>	
<p>PLACE OF BIRTH                  [REDACTED]</p>		<p>DATE OF DEATH                  [REDACTED]</p>	
<p>CAUSE OF DEATH                  [REDACTED]</p>		<p>PLACE OF DEATH                  [REDACTED]</p>	
<p>DATE OF INTERMENT                  [REDACTED]</p>		<p>PLACE OF INTERMENT                  [REDACTED]</p>	
<p>SIGNATURE OF REGISTRAR                  [REDACTED]</p>		<p>DATE                  [REDACTED]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13044

13029

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>David Edward Stouffer</u>		4. DATE OF DEATH Month <u>November</u> Day <u>17</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 17, 1958</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. <u>1</u> Months <u>1</u> Days <u>30</u> Min.
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Duke Edward Stouffer</u>		14. MOTHER'S MAIDEN NAME <u>Zada Kay Doyle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X Prematurity - 18 wks</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/12/58</u> , 19 <u>58</u> , to <u>11/17/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/12/58</u> , 19 <u>58</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Edward W. Ditto, III</u> , M.D.		Hagerstown, Md. Nov. 17, 1958	
PHYSICIAN'S NAME (Type) <u>Edward W. Ditto, III, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>11/18/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wash. County Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>NOV 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	



13056

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SHARPSBURG</b>			c. LENGTH OF STAY IN 1b <b>LIFE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SHARPSBURG</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FREDERICK</b> Middle <b>STULL</b> Last				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>25</b> Year <b>1958</b> 19			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPTEMBER 10 1884</b>		9. AGE (In years last birthday) <b>74 yrs.</b>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>JANITOR SHARPSBURG ELEMENTORY SCHOOL</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>SHARPSBURG WASH.CO.MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>WILHAM STULL</b>			14. MOTHER'S MAIDEN NAME <b>EMMA KATE STULL</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. LOTTIE STULL SHARPSBURG MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1-3 hours</b> <b>? years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May</b> , 19 <b>54</b> to <b>Nov. 25, 1958</b> , that I last saw the deceased alive on <b>July 10, 1958</b> , and that death occurred at <b>4 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sharpsburg Wash. D.C.</b> DATE SIGNED <b>Nov. 26, '58</b>							
ACTUAL SIGNATURE <b>Halvard Wanger</b>			PHYSICIAN'S NAME (Type) <b>HALVARD WANGER, M.D.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>NOV. 28 1958</b>		<b>MOUNTAIN VIEW CEMETERY</b>		<b>SHARPSBURG WASH.CO.MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Bast</b>			ADDRESS <b>Boonsboro Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 1 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**13057**  
**CERTIFICATE OF DEATH**

**13046**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithburg Rural</u>				c. LENGTH OF STAY IN 1b <u>years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Stull</u> Last				4. DATE OF DEATH Month <u>11</u> Day <u>30</u> Year <u>19 58</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/23/1902</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John Stull</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
14. MOTHER'S MAIDEN NAME <u>Amanda Stull</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-10-3580</u>		17. INFORMANT <u>Mrs. Nellie Stull, Smithburg, Md. Rt. 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage &amp; Terminal Pneumonia</u> DUE TO (b) <u>Terminal Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493X Falciparum</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>26 Nov 58</u> to <u>26 Nov 58</u> , that I last saw the deceased alive on <u>26 Nov 58</u> , and that death occurred at <u>1:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. J.D. Wilson</u> M.D.				ADDRESS (Street, City or Town, State) <u>HAGERSTOWN, MARYLAND</u> DATE SIGNED <u>12/1/58</u>			
PHYSICIAN'S NAME (Type) <u>Dr. J.D. Wilson</u>				Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>12/3/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Quincy, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Company, Middletown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fries</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

THE UNIVERSITY OF CHICAGO

13030

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>5 months - 7 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN Md State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ruth</u> First <u>AMBROSIA</u> Middle <u>SUMMERS</u> Last				4. DATE OF DEATH <u>November 30</u> 19 <u>58</u> Month Day Year			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 14 1900</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR: Months <u>5</u> Days <u>10</u> Hours <u>11</u> Min. <u>2</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAUNDRESS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LAUNDRY</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>			
13. FATHER'S NAME <u>FRANK R SUMMERS</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE JOHNSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Ruth PERKINS Philadelphia - 2543 N-24 PA.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA AND CONGESTION</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>RHEUMATIC HEART DISEASE, CHRONIC</u> DUE TO (c) <u>45 YRS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 23</u> , 19 <u>58</u> , to <u>Nov 30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 28</u> , 19 <u>58</u> , and that death occurred at <u>11:35 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Francis R. Audygh</u> M.D.				ADDRESS (Street, city or town, state) <u>1500 Pennsylvania Ave</u>		DATE SIGNED <u>11-30-58</u>	
PHYSICIAN'S NAME (Type) <u>EVANISTO R. LARDIZOBAL</u>				<u>HAGERSTOWN MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-3-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fredrick Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Hight</u>				ADDRESS <u>24. W. 1911 SAINT</u>		24a. REC'D BY REGISTRAR DATE <u>12-13-58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Robert S. Evans</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13031

## CERTIFICATE OF DEATH

13048

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wasshington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Md.</b> <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. Co. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle <b>R</b> Last <b>Tressler</b>		4. DATE OF DEATH Month <b>11</b> Day <b>20</b> Year <b>19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 18, 1898</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months <b>60</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Kraiss Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>State Line, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Tressler</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Ledy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>723-18-3385</b>	
17. INFORMANT <b>Mrs. Pearl Tressler</b>		Address <b>Clearspring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>200.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Retroperitoneal Lymphosarcoma</b> DUE TO (c) <b>unknown</b>			INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>0</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 15, 1958</b> to <b>Nov. 20, 1958</b> , that I last saw the deceased alive on <b>November 20, 1958</b> , and that death occurred at <b>5:40 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Clear Spring, Md.</b> DATE SIGNED <b>11/22/58</b>			
ACTUAL SIGNATURE <b>Archie Robert Cohen</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D. Clear Spring, Md. 11/22/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>11-23-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Shanks Ch. of Brethren Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Greencastle, Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>NOV 25 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraiss</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





13032

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HENRY CHRISTIAN TRIESLER</u>				4. DATE OF DEATH Month Day Year <u>November 22 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 9 1892</u>		9. AGE (In years lost birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Broker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stock</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore City Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Christian G. Triesler</u>				14. MOTHER'S MAIDEN NAME <u>Sophie K. Wager</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give year or date of service) <u>214-09-6404</u>		17. INFORMANT Address <u>Mrs Isabelle Dixon Triesler</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>45 minutes</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old myocardial infarction</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Nov 21</u> , 19 <u>58</u> , to <u>Nov 22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 22</u> , 19 <u>58</u> , and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>170 W Washington St Hagerstown Md.</u> DATE SIGNED <u>11/24/58</u>							
ACTUAL SIGNATURE <u>R. S. Stauffer</u>				M.D. <u>170 W Washington St</u>			
PHYSICIAN'S NAME (Type) <u>R. S. STAUFFER</u>				<u>Hagerstown Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/24/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 28 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delayed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES EARL RAY		35		M		W		4/4/68	
PLACE OF DEATH		CITY		COUNTY		STATE		ZIP CODE	
MEMPHIS		MEMPHIS		MEMPHIS		TN		38103	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION	
HEART DISEASE		NATURAL		PROFESSOR		HIGH SCHOOL		METHODIST	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF MARRIAGE		NAME OF SPOUSE		NAME OF FATHER	
1/5/33		MEMPHIS, TN		1/1/60		JANE RAY		JAMES EARL RAY	
DATE OF INTERVIEW		NAME OF INTERVIEWER		NAME OF WITNESS		NAME OF SIGNER		NAME OF REGISTRAR	
4/4/68		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13058

CERTIFICATE OF DEATH

13050

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>21 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garlock Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>Ellen</b> Last <b>Via</b>		4. DATE OF DEATH Month <b>11</b> Day <b>10</b> Year <b>19 58</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 30, 1884</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b> Hours <b>19</b> Min. <b>58</b>	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew Morgan</b>		14. MOTHER'S MAIDEN NAME <b>Martha Rohrer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Katherine Marchal</b>		Address <b>Washington, D. C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis of abd</b> <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Cervix</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis &amp; hemiplegia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 17, 1958</b> , to <b>10 Nov, 1958</b> , that I last saw the deceased alive on <b>6 Nov, 1958</b> , and that death occurred at <b>12:40 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. Edgar Hoachlander</b>		ADDRESS (Street, city or town, state) <b>115 W. Wash. St. Hagerstown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>E. Edgar Hoachlander</b>		DATE SIGNED <b>Nov 10 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>11-13-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>NOV 12 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	



13059

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Prince William</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manassas</u> 83X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Rt 11 3 miles South</u>		d. STREET ADDRESS <u>111 Travis Street</u>	
3. NAME OF DECEASED (Type or print) First <u>BETTY</u> Middle <u>LOUISE</u> Last <u>WADEL</u>		4. DATE OF DEATH Month <u>November</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13, 1932</u>
9. AGE (In years last birthday) <u>26</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shippensburg, Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Henry Hancock</u>		14. MOTHER'S MAIDEN NAME <u>Pearl Edna Waren</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Clarence Levi Wadel</u>		Address <u>Manassas, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe concussion and shock</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c), stating the underlying cause last. (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in auto that was involved in head-on crash with another automobile</u>	
20c. TIME OF INJURY Month, Day, Year <u>1:40</u> <u>Nov. 21</u> <u>58</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) (County) (State) <u>Hagerstown Wash Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		DATE SIGNED <u>11-3-58</u>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/5/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Shippensburg, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Rouzer</u>		24a. REC'D BY REGISTRAR <u>NOV 6 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

13053

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		Jan 15, 1950	
Residence		Occupation		Cause of Death		Manner of Death	
123 Main St, Baltimore, Md		Teacher		Heart Disease		Natural	
Physician		Hospital		Burial or Disposition		Remarks	
Dr. Smith		St. Mary's		Buried			
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Examination		Time of Examination		Place of Examination		Initials of Examiner	
Jan 16, 1950		10:00 AM		Home		[Initials]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13033  
CERTIFICATE OF DEATH

13052

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>	
c. LENGTH OF STAY IN b <b>1 1/2 days</b>		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>312 East Main Street</b>	
3. NAME OF DECEASED (Type or print) First <b>CYNTHIA</b> Middle <b>MARIE</b> Last <b>WATT</b>		4. DATE OF DEATH Month <b>November</b> Day <b>12</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 11, 1958</b>
9. AGE (In years lost birthday) yrs. <b>1</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>12</b> Hours <b>12</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter Watt</b>		14. MOTHER'S MAIDEN NAME <b>Geraldine Spirito</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Geraldine Watt</b>		Address <b>Thurmont, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5 Prematurity (2 chs 5 og)</b> DUE TO <b>Atelectasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atelectasis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 days</b> <b>1 1/2 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/11</b> , 19 <b>58</b> , to <b>11/12</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/12</b> , 19 <b>58</b> , and that death occurred at <b>11:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. M. Bacon</b>		ADDRESS (Street, city or town, state) <b>101 King St. Hagerstown Md</b>	
PHYSICIAN'S NAME (Type) <b>A. M. Bacon</b>		DATE SIGNED <b>11/14/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/15/1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Agnes Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lockhaven, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>		24a. REC'D BY REGISTRAR <b>NOV 17 '58</b>	
ADDRESS <b>Hagerstown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

2081212XVI

CERTIFICATE OF DEATH

1903

U.S. PUBLIC HEALTH SERVICE

DEPARTMENT OF HEALTH

BALTIMORE, MD.

DATE OF DEATH

1903

PLACE ON DEATH CERTIFICATE

NAME

AGE

SEX

1903

1903

1903

DEPARTMENT OF HEALTH

PLACE ON DEATH CERTIFICATE

DEPARTMENT OF HEALTH

PLACE ON DEATH CERTIFICATE

DEPARTMENT OF HEALTH

PLACE ON DEATH CERTIFICATE

DEPARTMENT OF HEALTH

PLACE ON DEATH CERTIFICATE

DEPARTMENT OF HEALTH

PLACE ON DEATH CERTIFICATE

DEPARTMENT OF HEALTH

RECEIVED BY THE DEPARTMENT OF HEALTH  
BALTIMORE, MD.  
1903

13034

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garlock Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Charles</b> Last <b>Weigand</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>26</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 27, 1878</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick County, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Jacob Weigand</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Jane Clopper</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-12-0352</b>	
17. INFORMANT Address <b>Mrs. E. C. Weigand -1035 Beechwood Drive Hagerstown, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma prostate</b> DUE TO <b>Acute pulmonary artery thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>none 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 19 48</b> to <b>Nov. 26 19 58</b> , that I last saw the deceased alive on <b>Nov. 19 19 58</b> , and that death occurred at <b>4:55 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S. Robert Wells</b> M.D.		ADDRESS (Street, city or town, state) <b>115 N. Potomac Street</b> DATE SIGNED <b>11-28-58</b>	
PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.</b>		<b>Hagerstown, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-29-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Aven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. G. Hunt</b> ADDRESS <b>Rest Aven Funeral Chapel Inc.-Hagerstown, Md</b>		24a. REC'D BY REGISTRAR <b>DEC 1 '58</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hunt</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John A. Smith		Male		45		Jan 15, 1880		Boston, Mass.	
Cause of Death		Disease		Duration		Time of Day		Place of Death	
Heart Disease		Myocardial Infarction		24 hours		10:30 AM		Home	
Occupation		Education		Marital Status		Religion		Signature of Physician	
Carpenter		High School		Married		Roman Catholic		[Signature]	
Signature of Informant		Relationship		Signature of Registrar		Date of Registration		Place of Registration	
[Signature]		Son		[Signature]		Jan 20, 1925		Boston, Mass.	

13035

## CERTIFICATE OF DEATH

13054

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>5 HOURS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GURNEA</b> Middle <b>WILKINSON</b> Last <b>WILKINSON</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>17</b> Year <b>1958</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 2 1876</b>	
9. AGE (In years last birthday) <b>82</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE KEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON COUNTY MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>EZRA BURTNER</b>		14. MOTHER'S MAIDEN NAME <b>SARAH HARP</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MISS EMMA R. BURTNER KEEDYSVILLE MD.</b>		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombo-phlebitis of the left leg</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease with cellulitis of the left leg</b> DUE TO (c) <b>5 years. 3 days.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mempplegia - left sided.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/17/58</b> 19____, to <b>11/19/58</b> 19____, that I last saw the deceased alive on <b>11/17/58</b> 19____, and that death occurred at _____ M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Sharpsburg, Md.</b>		DATE SIGNED <b>11/19/58.</b>		ACTUAL SIGNATURE <b>Walter H. Shealy</b> M.D.	
PHYSICIAN'S NAME (Type) <b>Walter H. Shealy M. D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>NOV. 20 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>	
22d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH. CO. MD.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>John D. Bart</b> ADDRESS <b>Boonsboro Md</b>		24a. REC'D BY REGISTRAR <b>NOV 21 58</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Francis</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13036

## CERTIFICATE OF DEATH

Reg. Dist. No. 14343

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. # 1, Mercersburg, Penna. 75x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Jane Witter</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>16</u> Year <u>19 58</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19, 1909</u>
9. AGE (In years (last birthday) yrs.) <u>49</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Williamson, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>G. Andrew Heckman</u>		14. MOTHER'S MAIDEN NAME <u>Pearl Foust Heckman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>180-10-3097</u>	
17. INFORMANT <u>Alvin S. Witter, Rt. #1, Mercersburg, Pa.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> <u>452x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Due to prolonged recumbency. (Akinetic mutism)</u> DUE TO (c) <u>Due to ruptured aneurysm of anterior communicating artery.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>7 wks.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/14</u> , 19 <u>58</u> , to <u>11/16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/16</u> , 19 <u>58</u> , and that death occurred at <u>2 p. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>A. F. Abdullah</u> M.D. <u>A. F. Abdullah, M.D.</u>		<u>11/17/58</u>	
PHYSICIAN'S NAME (Type) <u>A. F. Abdullah, M. D.</u>		<u>132 N. Potomac St., Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/19/58</u>	
22c. NAME OF GEMETERY OR CREMATORY <u>WELSH RUN BROTHERN, Franklin Co, Mercersburg, Pa.</u>		22d. LOCATION (City, town, or county) (State) <u>Mercersburg, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. M. Swinger</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 11 '58</u>	
ADDRESS <u>MERCERSBURG, PA.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES J. JONES		M		45		JAN 15 1900		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
MARRIAGE		DATE		PLACE		CITY		COUNTY		STATE		CITY		COUNTY	
MARRIED		JAN 15 1920		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
EDUCATION		SCHOOL		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
HIGH SCHOOL		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
OCCUPATION		BUSINESS		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
BUSINESS		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
CAUSE OF DEATH		HEART DISEASE		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
HEART DISEASE		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
MANNER OF DEATH		NATURAL		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
NATURAL		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
PLACE OF DEATH		HOME		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
HOME		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
DATE OF DEATH		JAN 15 1945		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
JAN 15 1945		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
SIGNATURE OF DECEASED		JAMES J. JONES		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
JAMES J. JONES		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
SIGNATURE OF WITNESS		JAMES J. JONES		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
JAMES J. JONES		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
SIGNATURE OF PHYSICIAN		JAMES J. JONES		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
JAMES J. JONES		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
SIGNATURE OF REGISTRAR		JAMES J. JONES		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
JAMES J. JONES		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK	

13037

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Earl Walter Young		4. DATE OF DEATH Month 11 Day 26 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 28, 1902
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) shoe worker		10b. KIND OF BUSINESS OR INDUSTRY Southern Shoe Co	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Newton J. Young		14. MOTHER'S MAIDEN NAME Mary Daley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-1594	
17. INFORMANT Earl H. Young		Address Washington, D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 Cirrhosis of Liver - with DUE TO (b) Post operative Hepatic Coma DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 8 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity (b) Benign prostate hypertrophy			INTERVAL BETWEEN ONSET AND DEATH 10 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 2, 1958, to Nov 26, 1958, that I last saw the deceased alive on Nov 26, 1958, and that death occurred at 2:35 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward W. Ditto III M.D.		ADDRESS (Street, city or town, state) 217 W. Washington St. DATE SIGNED 11-28-58	
PHYSICIAN'S NAME (Type) Dr. E. W. Ditto III		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL, (Specify) burial	22b. DATE THEREOF 11-29-58	22c. NAME OF CEMETERY OR CREMATORY Rest Haven	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE DEC 1 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS



MASSACHUSETTS DEPARTMENT OF HEALTH

BUREAU OF VITAL RECORDS

FILE

13060

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SAN MAR</b>		c. LENGTH OF STAY IN 1b <b>30 MONTHS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KEEDYSVILLE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FAHRNEY KEEDY MEMORIAL HOME</b>				d. STREET ADDRESS <b>MAIN STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SADIA</b> Middle <b>M</b> Last <b>ZIMMERMAN</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>21</b> Year <b>1958</b> 19			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 6 1874</b>		9. AGE (In years last birthday) <b>84</b> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED TELEPHONE OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>C. and P. TEL. CO.</b>		11. BIRTHPLACE (State or foreign country) <b>NEAR KEEDYSVILLE WASH. CO. MD. U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>NICODEMUS ZIMMERMAN</b>				14. MOTHER'S MAIDEN NAME <b>ROSANNA SNYDER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213 09 8525</b>		17. INFORMANT <b>MRS. J. L. MULLENDORE</b> Address <b>104 EAST IRVIN AVE. HAGERSTOWN MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 9, 1958</b> , to <b>Nov. 21, 1958</b> , that I last saw the deceased alive on <b>Nov. 20, 1958</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. W. Sullivan</b>				ADDRESS (Street, city or town, state) <b>Boonsboro Md.</b>		DATE SIGNED <b>11/21/58</b>	
PHYSICIAN'S NAME (Type) <b>G. W. Sullivan</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>NOV. 23 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FAIRVIEW CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>KEEDYSVILLE WASH. CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Bast</b>				ADDRESS <b>Boonsboro Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 26 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Carling S. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. PLACE OF DEATH	
JAMES EARL RAY		MALE		39		JAN 5 1928		MEMPHIS, TENN.		MEMPHIS, TENN.	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. MEDICAL HISTORY		11. PRESENT ILLNESS		12. TIME OF DEATH	
ATTORNEY		HEART DISEASE		NATURAL		NONE		HEART ATTACK		10:00 AM	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED		16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF CORONER		18. SIGNATURE OF JUDGE	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
19. NAME OF FUNERAL HOME		20. NAME OF CORONER		21. NAME OF JUDGE		22. NAME OF WITNESSES		23. NAME OF DECEASED		24. NAME OF PLACE OF DEATH	
[Name]		[Name]		[Name]		[Name]		[Name]		[Name]	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE DISTRICT OF COLUMBIA, IN THE CITY OF WASHINGTON, D.C., AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE DISTRICT OF COLUMBIA, IN THE CITY OF WASHINGTON, D.C., AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE DISTRICT OF COLUMBIA, IN THE CITY OF WASHINGTON, D.C.